Policy Number	**PSY301.014**
Policy Effective Date	**12/15/2024**

Autism Spectrum Disorders (ASD)

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Related Policies (if applicable)
PSY301.021: Applied Behavior Analysis (ABA) for Autism Spectrum Disorder (ASD) Diagnosis
THE803.014 Speech-Language Therapy (SLT)
THE803.010 Physical Therapy (PT) and Occupational Therapy (OT) Services

Disclaimer

Carefully check state regulations and/or the member contract.
Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Legislative Mandates

EXCEPTION: For Illinois only: Illinois Public Act 103-0458 [Insurance Code 215 ILCS 5/356z.61] (HB3809 Impaired Children) states all group or individual fully insured PPO, HMO, POS plans amended, delivered, issued, or renewed on or after January 1, 2025 shall provide coverage for therapy, diagnostic testing, and equipment necessary to increase quality of life for children who have been clinically or genetically diagnosed with any disease, syndrome, or disorder that includes low tone neuromuscular impairment, neurological impairment, or cognitive impairment.

Coverage

NOTE 1: State Legislation may apply. Carefully check for legislative mandates that may apply for each plan.

NOTE 2: For information regarding Applied Behavior Analysis (ABA) or Early Intensive Behavioral Intervention (EIBI) please refer to medical policy PSY301.021 Applied Behavior Analysis (ABA) for Autism Spectrum Disorder (ASD) Diagnosis.

Certain procedures and services (listed below) **may be considered medically necessary** when performed for the assessment, diagnosis, and/or treatment of autism spectrum disorders in ANY of the following circumstances:

- No babbling by age 12 months;
- No gesturing by age 12 months (e.g., pointing, waving bye-bye);
- No single words by age 16 months;
- No two-word spontaneous phrases (not just echolalic) by age 24 months; and/or
- Any loss of any language or social skills at any age.

For patients who meet the above criteria, the services and procedures that **may be considered medically necessary** for diagnosis and treatment of autism include ANY of the following:

- Developmental surveillance at all well-child visits, including but not limited to:
  1. Medical evaluation and screening,
  2. Parent and/or child interview, including siblings with autism;
- Formal audiological evaluation;
- Evaluation (not treatment) by a Speech-Language Pathologist (See also THE803.014 Speech Therapy to determine eligibility for benefit coverage);
- Speech and language therapy for treatment of comorbid impairment (See also THE803.014 Speech Therapy to determine eligibility for benefit coverage);
- Evaluation by Occupational Therapist and/or Physical Therapist for comorbid physical impairment (See also THE803.010 Physical Therapy (PT) and Occupational Therapy (OT) Services for coverage criteria);
- Physical and/or occupational therapy for treatment of comorbid impairment (See also THE803.010 Physical Therapy (PT) and Occupational Therapy (OT) Services for coverage criteria);
- Blood lead level screening if developmental delay, exposure to high-risk environment, or pica are present;
- Genetic testing, specifically high-resolution chromosome studies (karyotype) and/or DNA analysis for Fragile X Syndrome (FraX), in ANY of the following situations:
  1. Mental retardation/intellectual disability is either present or cannot be excluded,
  2. Family history of either FraX, mental handicap, or learning disability,
  3. Dysmorphic physical features are present;
- Quantitative plasma amino acid assay to detect phenylketonuria (PKU);
- Selective metabolic testing (e.g., amino acids, organic acids, carnitine, trace metals) and/or toxicology studies if ANY of the following are present:
  1. Lethargy,
  2. Cyclic vomiting,
  3. Early seizures,
  4. Dysmorphic or coarse features,
  5. Mental retardation/intellectual disability (is either present or cannot be ruled out),
  6. Occurrence or adequacy of newborn screening for birth defect is questionable;

- Epileptiform sleep-deprived electroencephalogram (EEG) if ANY of the following are present:
  1. Clinical seizures,
  2. Suspicion of subclinical seizures (e.g., staring spells),
  3. History of developmental regression, i.e., clinically significant loss of social or communicative function at any age, but especially in toddlers and preschoolers.

Procedures, services, and therapies that **are considered experimental, investigational and/or unproven** for the routine diagnosis and/or treatment of ASD include, but are not limited to:

- Event-related brain potentials;
- Magnetoencephalography;
- Functional imaging modalities, including:
  1. Functional magnetic resonance imaging (fMRI),
  2. Single-photon emission computed tomography (SPECT),
  3. Positron-emission tomography (PET);
- Allergy testing (particularly food allergies for gluten, casein, candida, and other molds);
- Hair analysis for trace elements;
- Tests for:
  1. Celiac antibodies,
  2. Immunologic or neurochemical abnormalities,
  3. Micronutrients such as vitamin levels,
  4. Intestinal permeability studies,
  5. Stool analysis,
  6. Urinary peptides,
  7. Mitochondrial disorders, including lactate and pyruvate,
  8. Thyroid function,
  9. Erythrocyte glutathione peroxidase studies,
  10. Metabolic biomarker panel;
- Elimination diets;
- Nutritional supplements;
- Intravenous immune globulin infusion;
- Secretin infusion;
- Stem cell transplants;
- Chelation therapy and/or hyperbaric oxygen therapy (HBOT) (either alone or in combination);
- Sensory Integration Therapy (SIT);
- Auditory Integration Therapy (AIT);
- Music therapy;
- Vision therapy;
- Touch or massage therapy;
- Social stories;
- Floor time;
- Facilitated communication;

- Hippotherapy, animal therapy, or art therapy;
- Relationship Development Intervention (RDI).

Comfort items and/or over the counter products, including but not limited to, weighted blankets and weighted vests **are considered convenience items and are not covered benefits**.

Policy Guidelines

None.

Description

Autism is a complex and life-long developmental disability. A broad range of developmental disorders are collectively known as Autism Spectrum Disorders (ASD); these disorders include the following:

- Autism - the prototypical disorder of the group;
- Asperger's Syndrome - refers to individuals with autistic characteristics but relatively intact language abilities;
- Pervasive Developmental Disorder - Not Otherwise Specified (PDD-NOS)/Atypical Autism - refers to a collection of features that resemble autism but may not be as severe or as extensive;
- Rhett's Disorder - relatively rare, primarily affects females, and is a genetic disorder with hard neurological signs (including seizures) that become more apparent with age;
- Childhood Disintegrative Disorder (CDD) - rare, primarily affects males, and refers to children whose development appears normal for the first few years, but then regresses with loss of speech and other skills until the characteristics of autism are apparent.

The Centers for Disease Control and Prevention (CDC) include the following data and statistics on ASD concerning prevalence among children aged 8 years in 2020: (29)

- About 1 in 36 children has been identified with ASD according to estimates from CDC's Autism and Developmental Disabilities Monitoring (ADDM) Network.
- ASD is reported to occur in all racial, ethnic, and socioeconomic groups.
- ASD is nearly 4 times more common among boys than among girls.

While autism can be diagnosed at any age, it is usually diagnosed by age three years through late preschool age. Milder conditions within the autism spectrum, including Asperger's Syndrome and PPD-NOS may present later, if at all, and can be more difficult to recognize. Rhett's Syndrome and Childhood Disintegrative Disorder are rare but are more severe disorders. The following core features of ASD form the basis for diagnostic criteria used by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5):

- Impaired social interaction and social development,
- Impaired language, verbal and non-verbal communication,
- Restrictive and repetitive behavior patterns.

Possible indicators of ASD include:

- Does not babble, point, or make meaningful gestures by one year of age;
- Does not speak one word by 16 months of age;
- Does not combine two words by two years of age;
- Loses language or social skills.

Other indicators that may be present are:

- Does not respond to name;
- Poor eye contact;
- Doesn't seem to know how to play with toys;
- Excessively lines up toys or other objects;
- Is attached to one particular toy or object;
- Doesn't smile;
- At times seems to be hearing impaired;
- Unprovoked aggressive or violent behavior toward self or others;
- Problems with attention, concentration, or sleep;
- Unusual or inappropriate responses to sensory stimuli;
- Self-injury;
- Property destruction;
- Pica (a perverted appetite for substances not fit as food or of no nutritional value, e.g., clay, dried paint, starch, ice);
- Defiance and tantrums;
- Not wanting to cuddle or to be cuddled; or
- Physical over-activity or under-activity.

Children and adults with autism can exhibit any combination of these behaviors in any degree of severity. Also, two children with the same ASD diagnosis can behave completely different from each other and have different capabilities.

Early in life, developing infants are social beings; they gaze at people, turn toward voices, grasp a finger, smile. In contrast, autistic children have difficulty learning to engage in everyday human interaction. They avoid eye contact, prefer to be alone, seldom seek comfort or respond to parents' displays of anger or affection. They can be slower to learn to interpret social cues such as a smile, a wink, or a grimace, and they appear to have difficulty seeing things from another person's perspective. They also have difficulty regulating their emotions, which leads to apparent "immature" behavior, inappropriate emotional outbursts, disruptive behavior, and physical aggression. Some autistic children remain mute throughout their life. Those who do speak may use language in unusual or inappropriate ways; for example, they may not be able to combine words into meaningful sentences, or they may speak only one word or repeat the same word(s) over and over. Children who have milder forms of ASD may exhibit slight delays in language, or they may have large vocabularies but have difficulty carrying on a conversation. In addition, their body language may not be appropriate to what they are saying. Repetitive

behavior in autism can take the form of persistent, intense preoccupation. Consistency in the environment is very important as a small change in routine can be extremely disturbing to the autistic child.

Although autism is considered a neurological disability, the etiology is unknown. A number of causes have been suggested including genetics and heredity, problems during pregnancy or delivery, viral infections, metabolic imbalances, exposure to environmental chemicals, harmful substances ingested during pregnancy, and vaccines; none of these have been proven. Many children with ASD have some degree of mental retardation/intellectual disability, and about one in four develop seizures. Children with ASD tend to have certain medical conditions more often than expected such as FraX, tuberous sclerosis, congenital rubella syndrome, and untreated phenylketonuria (PKU).

A variety of treatment approaches have been developed that address the social, language, and behavioral difficulties of ASD. While many have not been proven to be effective, some general guidelines have emerged. Generally, interventions should:

- Begin early and focus on teaching functional skills of immediate and ongoing value in daily life,
- Be individualized to the type and severity of symptoms,
- Provide structure and clear guidelines, and
- Include family involvement.

Applied Behavioral Analysis (ABA), an Early Intensive Behavioral Intervention (EIBI), encompasses behavior modification training programs that are based on the theory that behavior is learned through interaction between an individual and the environment. (For additional information, see Medical Policy 301.021 Applied Behavior Analysis (ABA) for Autism Spectrum Disorders (ASD) Diagnosis).

Rationale

Autism spectrum disorders (ASD) diagnoses are complex; developmental disorders and associated co-morbidity commonly overlap. No specific medical test or procedure can confirm an autism diagnosis, and there is no proven cure. Although anecdotal reports suggest certain interventions may benefit some children, the same interventions may be entirely unhelpful for others. Little comparative research between treatment approaches has been done, partly because there are so many variables to be controlled. Various developmental, behavioral, and educational strategies have been developed and many have been adopted by various groups. Most have not been subjected to thorough, sound research that proves evidence of effectiveness, and there is no consensus regarding which strategy is most effective.

The American Academy of Neurology (AAN) has reviewed empirical evidence and developed practice parameters giving recommendations for the screening, diagnosis, and management of autism. (20) The AAN practice parameter has been endorsed by the American Academy of

Audiology, the American Academy of Pediatrics (AAP), the American Occupational Therapy Association, the American Psychological Association, the American Speech-Language-Hearing Association, the Autism National Committee, Cure Autism Now, the National Alliance for Autism Research, and the Society for Developmental Pediatrics. The AAN statement describes three levels of recommendations: 1) routine development surveillance and screening specifically for autism, 2) diagnosis and evaluation of autism, and 3) consensus-based principles of management.

AAN recommendations for routine surveillance and screening include:

- Developmental surveillance and screening at all well-child visits;
- Further developmental evaluation whenever a child fails to meet any of the following:
  1. Babbling and gesturing by 12 months,
  2. Single words by 16 months,
  3. Two-word phrases by 24 months, or
  4. Loss of any language or social skills at any age;
- Specific screening for autism using one of the validated instruments, e.g., the Checklist for Autism in Toddlers (CHAT) or the Autism Screening Questionnaire (ASQ);
- Formal audiologic assessment using an experienced pediatric audiologist;
- Lead screening in any child with developmental delay and/or pica and repeat periodically if pica persists.

Routine development surveillance and screening specifically for autism include both a confirmation that a recent (initial or updated within 36 months) Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis of autism spectrum disorder has been established by a formal developmental and/or psychometric evaluation. Letters of medical necessity, visit or encounter notes, prescriptions, or referral notes **are not** the same as a differential diagnosis obtained via the use of a diagnostic instrument, independent medical judgement describing how diagnostic criteria is met via direct observation of the member, and a review of collateral documents and documented within the formal developmental and/or psychometric evaluation done by a qualified diagnostic physician or diagnostic specialist.

Like the screening recommendations noted above, the American Academy of Pediatrics has related recommendations that all children be screened for ASD at ages 18 and 24 months, along with regular developmental surveillance. (30) Toddlers and children should be referred for diagnostic evaluation when increased risk for developmental disorders (including ASD) is identified through screening and/or surveillance.

The American Academy of Child and Adolescent Psychiatry (AACAP) (2014) and the AAP (2015, 2020) made the following similar recommendations (31, 32, 33):

- The developmental assessment of young children and the psychiatric assessment of all children should routinely include questions about ASD symptomatology (Clinical Standard [CS]).

- If the screening indicates significant ASD symptomatology, a thorough diagnostic evaluation should be performed to determine the presence of ASD [CS].
- Clinicians should coordinate an appropriate multidisciplinary assessment of children with ASD [CS].

AAN recommendations for the evaluation and diagnosis for autism include:

- Genetic testing, specifically high-resolution chromosome studies (karyotype) and DNA analysis for FraX syndrome if:
  1. Mental retardation/intellectual disability is present or cannot be excluded,
  2. There is a family history of FraX or undiagnosed mental retardation/intellectual disability, or
  3. Dysmorphic features are present;
- Selective metabolic testing if any of the following are present:
  1. Lethargy, cyclic vomiting, or early seizures,
  2. Dysmorphic or coarse features,
  3. Mental retardation/intellectual disability either is present or cannot be ruled out, and/or
  4. Occurrence or adequacy of newborn screening for birth defect is questionable;
- Evidence is inadequate to recommend an electroencephalogram (EEG) study in all individuals with autism; indications for an adequate sleep-deprived EEG with appropriate sampling of slow wave sleep include clinical seizures, suspicion of subclinical seizures, and/or a history of regression at any age; recording of event-related potentials and magnetoencephalography are considered research tools at the present time;
- Clinical evidence does not support the routine use of clinical neuroimaging in the diagnostic evaluation of autism, even in the presence of megalocephaly;
- There is inadequate supporting evidence for hair analysis, celiac antibodies, allergy testing (particularly food allergies for gluten, casein, candida, and other molds), immunologic or neurochemical abnormalities, micronutrients such as vitamin levels, intestinal permeability studies, stool analysis, urinary peptides, mitochondrial disorders, thyroid function tests, or erythrocyte glutathione peroxidase studies.

AAN recommendations for management of ASD include:

- Speech, language, and communication evaluations;
- Occupational therapy and physical therapy evaluations;
- Neuropsychological, behavioral, and academic assessments.

Functional neuroimaging studies such as positron-emission tomography (PET), single-photon emission computed tomography (SPECT), and functional magnetic resonance imaging (fMRI) have revealed certain abnormalities, but the value of functional neuroimaging has not been established for the diagnosis of autism. During the 1970s, computed tomography (CT) studies, which at that time were standard for assessing children with autism, reported a wide range of brain imaging abnormalities, suggesting associated underlying structural disorder. However, Damasio et al. demonstrated that such abnormalities were incidental to coexisting anatomic

disorders unrelated to autism. (2) Consequently, neuroimaging studies confirmed the absence of significant brain abnormalities. The AAN review concluded that there is no evidence to support the role of routine clinical neuroimaging studies (PET, SPECT, or fMRI) in the clinical diagnosis of autism, even in the presence of megalencephaly.

The incidence of epilepsy in autistic children is estimated at about 7% to 14%; the cumulative prevalence by adulthood is estimated at 20% to 35%. However, the AAN review found inadequate evidence to recommend an EEG study in all individuals with autism. Evidence did show that autism with regression and Childhood Disintegrative Disorder (CDD) have both been associated with seizures or epileptiform sleep-deprived EEG, with adequate sampling of slow wave sleep; these were more prevalent in children with regression who demonstrated cognitive deficits. Also, there may be a causal relationship between a subgroup of children with autistic regression and EEG-defined "benign focal epilepsies." An adequate sleep-deprived EEG with appropriate sampling of slow wave sleep is indicated in the presence of clinical seizures or suspicion of subclinical seizures, or a history of regression of social or communicative function at any age. The AAN also stated that there is insufficient evidence to suggest a role for event-related potentials or magnetoencephalography in the evaluation of autism.

In 2001, the National Research Council, including the National Academy of Sciences, formed a committee to integrate the scientific, theoretical, and policy literature for evaluating the scientific evidence concerning the effects of educational interventions for young children with autism. The committee reported there is little evidence concerning the effectiveness of discipline-specific therapies, and no adequate comparisons of different comprehensive treatments; research would provide more valuable information if there were minimal standards in design and description of intervention projects. (22)

Occupational therapy using sensory integration techniques is sometimes used for children with ASD. Although some believe occupational therapy is subjectively effective in educational and clinical settings, research data to support its effectiveness is scant. Occupational and physical therapy may be helpful in addressing coordination and motor planning deficits occurring in some children with ASD.

Auditory integration training (AIT) is based on the unproven theory that symptoms in ASD are caused by auditory perception defects resulting in distortions of sound or auditory hypersensitivity (hyperacusis). A single pilot study of 17 patients supported the hypothesis that AIT improved some autistic behaviors, but AIT did little to decrease hyperacusis. In 2000, Mudford et al. conducted a crossover study that showed no difference between the AIT group and the control group. (7) Also, in 2000, Dawson et al. reviewed evidence and concluded that the studies do not support the use of either AIT or sensory integration therapy (SIT) for autism. (8)

Facilitated communication (FC) is a somewhat controversial technique. Bebko et al. found significant facilitator influence of responses and that some students became even more passive

communicators when FC is used. (23) Multiple scientific studies have failed to demonstrate the effectiveness of FC as a treatment, and it remains investigational.

Disorders of metabolism, nutritional supplements, and food allergies have each been studied as a cause of autism. But the percentage of autistic children who have a metabolism disorder is probably less than 5%; some experts agree it is considerably less than 5%. Findling et al. conducted a ten-week double-blind, placebo-controlled trial to determine both the efficacy and safety of high doses of pyridoxine and magnesium (HDPM) as a way to decrease physical aggression and improve social interaction in autism; HDPM was ineffective in this study. (5) Other investigations have failed to prove a higher prevalence of food allergies in children with ASD.

The AAN guidelines state that for the diagnosis and management of autism, there is inadequate supporting evidence for hair analysis, celiac antibodies, allergy testing (particularly food allergies for gluten, casein, candida, and other molds), immunologic or neurochemical abnormalities, micronutrients such as vitamin levels, intestinal permeability studies, stool analysis, urinary peptides, mitochondrial disorders (including lactate and pyruvate), thyroid function tests, or erythrocyte glutathione peroxidase studies.

Secretin, a peptide hormone that stimulates pancreatic secretion, has been presented as an effective treatment for autism based on anecdotal evidence. Multiple randomized, double-blind, placebo-controlled trials of both single and multiple doses of secretin have been published. In 2005, a Cochrane Database Review concluded that there is no evidence that intravenous secretin, in either single or multiple doses, is effective in improving the core features of autism or the quality of life for affected individuals. (24)

Concerns have been raised that suggest ASD might be caused by early childhood exposure to environmental toxins, such as mercury from fish (methylmercury) or vaccines (thimerosal). There are no published studies linking mercury exposure to the development of ASD or demonstrating that children with ASD have had greater exposure to mercury than have unaffected children. Hair analysis and chelation tests may detect mercury level but are not recommended; hair analysis is subject to false positive results, and there is no evidence that chelation therapy will improve developmental function when given for mercury toxicosis. Also, chelating agents themselves can cause hepatotoxicity and allergic reaction. However, children with developmental delay may exhibit pica or have more extensive hand-to-mouth activity than other children, and thus may be at increased risk for lead toxicity. The National Center for Environmental Health of the Centers for Disease Control and Prevention recommends lead poisoning screening for children with developmental delay even without frank pica.

In some studies, cerebral hypoperfusion has been correlated with repetitive, self-stimulatory, and stereotypical behaviors, and impairments in communication, sensory perception, and social interaction. Hyperbaric oxygen therapy (HBOT) has been used with some clinical success in several cerebral hypoperfusion conditions. Several studies on the use of HBOT and HBOT in combination with chelation in autistic children are currently underway. In 2007, Rossignol et al.

conducted a prospective study of 18 children with autism, aged 3-16 years, who were given 40 HBOT sessions of 45 minutes each, either at 1.5 atmospheres (atm) and 100% oxygen, or at 1.3 atm and 24% oxygen. (15) Although some of the results did appear to be positive, the authors concluded that since this was an open-label study, definitive statements regarding the efficacy of HBOT for the treatment of autism must await results from double-blind controlled trials.

Immunologic abnormalities have been suggested as an autoimmune cause of autistic symptoms. In 1998, A.V. Plioplys investigated whether intravenous immunoglobulin would improve autistic symptoms. The study enrolled ten autistic children with immunologic abnormalities, as demonstrated on blood tests. (6) Only one child had significant improvement. Once the treatment program was completed, this child gradually deteriorated over a five-month time period and fully reverted to his previous autistic state. Plioplys concluded that the use of immunoglobulin to treat autistic children should be undertaken only with great caution, and only under formal research protocols. Larger controlled studies are needed to assess this kind of treatment, but there is not scientific evidence to justify the use of infusions of immunoglobulin to treat children with ASD.

Stem-cell transplantation therapy is also being evaluated as a possible treatment for autism. Many of the studies have small sample sizes and therefore limit extrapolation of the results to the general population of patients with ASD. Bradstreet et al. (2014) investigated the safety and efficacy of fetal stem-cell (FSC) transplantation in treating children diagnosed with ASD. Transplantations consisted of two doses of intravenously and subcutaneously administered FSCs. Patients were evaluated pre-transplant and 6 and 12 months following the transplantations. The Autism Treatment Evaluation Checklist (ATEC) test and Aberrant Behavior Checklist (ABC) scores were noted to have statistically significant differences for the domains of speech, sociability, sensory, and overall health when compared to the pretreatment values. The authors note no adverse events of significance were observed in the children with ASD who were treated with FSCs. The authors also recognized the use of FSCs remains controversial for the present, but indicate “the results of this study, however, warrant additional investigations into the mechanisms of cell therapies for ASDs, while prompting the exploration of FSCs as "biopharmacies" capable of manufacturing the full array of cell-signaling chemistry.” (21)

Currently, there is no reliable diagnostic biomarker for ASD. Recommendations for routine surveillance and screening as well as diagnosis and evaluation of ASD have been discussed previously. Recently, NeuroPointDX has developed a tool that is intended to identify metabolic imbalances by analyzing a blood sample. The NeuroPointDX ASD Panel has been proposed as an additional tool that parents and physicians can use to reach a diagnosis sooner. The NeuroPointDX’s website notes the CAMP (Children’s Autism Metabolome Project) study. (26) The CAMP study evaluated a lab test to identify children with metabolic imbalances that are associated with ASD. The website at the time of this review indicates the goal of enrolling 1,100 children, 18-48 months old. ClinicalTrials.gov notes the clinical trial Children’s Autism Metabolome Project (CAMP-01) Study (NCT02548442), however no results are posted at this time. (27) The estimated study completion date is listed as August 2023. At this time, there is insufficient quantity and quality of studies to support the use of the NeuroPointDX ASD Panel.

There are insufficient well-constructed, scientific studies in the published literature that provide evidence to support the efficacy of vision therapy, touch therapy, massage therapy, floor time, social stories, hippotherapy, animal therapy, or art therapy for the treatment of ASD.

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	0063U, 0318U, 0322U, 70450, 70460, 70470, 70496, 70551, 70552, 70553, 76390, 78600, 78601, 78605, 78606, 78608, 78609, 78610, 78803, 82016, 82017, 82127, 82128, 82131, 82136, 82139, 82379, 83015, 83655, 83825, 83918, 83919, 83921, 87230, 88245, 88248, 88249, 88261, 88262, 88263, 88264, 90281, 90283, 90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90849, 90853, 90863, 90882, 90887, 90889, 90899, 92507, 92521, 92522, 92523, 92524, 92650, 92651, 92652, 92653, 95004, 95018, 95024, 95027, 95028, 95044, 95052, 95056, 95060, 95065, 95070, 95076, 95079, 95812, 95813, 95816, 95819, 95822, 95925, 95927, 95928, 95930, 95965, 95966, 95967, 96105, 96110, 96112, 96113, 96116, 96121, 96125, 97533, 99183
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Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does not have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been developed since this medical policy document was written. See Medicare's National Coverage at <https://www.cms.hhs.gov>.

Policy History/Revision	
Date	**Description of Change**
12/15/2024	Document updated with literature review. Coverage unchanged. References 32-33 were added; other references were updated.
08/15/2023	Document updated with literature review. Coverage unchanged. References 29-31 were added; other references were updated.
01/01/2023	Reviewed. No changes.
11/15/2021	Document updated with literature review. The following changes were made to Coverage: Removed the following examples from procedures, services, and therapies that are considered experimental, investigational and/or unproven: Picture Exchange Communication Systems, and Pivotal Response Treatment. Reference 28 added, others updated.
02/01/2021	Document updated with literature review. The following change was made to Coverage: Removed Applied Behavior Analysis (ABA) and other Early Intensive Behavioral Intervention (EIBI) programs from the experimental, investigational and/or unproven list of procedures, services, and therapies. References updated.
04/15/2019	Document updated with literature review. The following changes were made to the Coverage section: 1) Added the following test to the experimental, investigational and/or unproven section: Metabolic Biomarker panel, 2) Added the following therapy to the experimental, investigational and/or unproven section: Stem-cell transplants, 3) Added Comfort items and/or over the counter products, including but not limited to, weighted blankets and weighted vests are considered convenience items and are not covered benefits, 4) Removed the NOTE that applied to the BCBSMT plan only. The following reference numbers were added: 19, 21-27. One reference was removed.
01/01/2017	Document updated with literature review. Coverage concerning Applied Behavior Analysis (ABA) and other Early Intensive Behavioral Intervention (EIBI) programs have been moved to a new medical document PSY301.021 Applied Behavior Analysis (ABA) for Autism Spectrum Disorders (ASD) Diagnosis. Coverage that remains on this document PSY301.014 Autism Spectrum Disorders (ASD) is unchanged.
02/15/2016	Document updated with literature review. Coverage unchanged.
09/01/2014	Reviewed. No changes.
08/15/2013	Document updated with literature review. No changes to coverage.
09/15/2011	Document updated with literature review. The following changes were made to the Coverage: 1) Relationship Development Intervention (RDI) is considered experimental, investigational and unproven; 2) Applied Behavior Analysis (ABA) and other Early Intensive Behavioral Intervention (EIBI) programs remain experimental, investigational and unproven. However, when coverage of ABA and/or EIBI are state-mandated or specifically included in a member's benefit plan, the listed medical necessity criteria will

	be applied for A) initial therapy, or B) continued therapy, or C) discontinuation of therapy.
09/15/2008	Revised/updated entire document
01/01/2008	Legislation revised/added/deleted
01/01/2007	Coverage Revised
07/15/2006	New medical document