



BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

Early Childhood Developmental Disorders (ECDD), Including Autism Corporate Medical Policy

File name: Early Childhood Developmental Disorders

File code: UM.SPSVC.09

Origination: 07/2011

Last Review: 010/2013

Next Review: 010/2014

Effective Date: 01/01/2014

Document Precedence

BCBSVT Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract language, the member's contract language takes precedence.

Medical Policy

Description

Developmental change may occur as a result of genetically-controlled processes known as maturation, or as a result of environmental factors and learning, but most commonly involves an interaction between the two. Developmental change may lead to longer developmental disabilities in an individual patient.

Developmental disabilities are a diverse group of severe chronic conditions that are due to mental and/or physical impairments. People with developmental disabilities have problems with major life activities such as language, mobility, learning, self-help, and independent living. Developmental disabilities begin anytime during development up to 22 years of age and usually last throughout a person's lifetime-
*Autism spectrum disorders (ASDs) are a group of developmental disabilities. (CDC definition)

According to Vermont law, Early Childhood Developmental Disorder (ECDD) is defined as a childhood mental or physical impairment or combination of mental and physical impairments that results in functional limitation in major life activities, accompanied by a diagnosis defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Disease (ICD). The term includes autism spectrum disorders, but does not include a learning disability.

AUTISM DISORDER

Autism disorder was first described by Dr. Leo Kanner in 1943. Autism impacts the normal development of the brain in the areas of communication skills and social interaction; it is four times more common in males than females. The onset of the condition usually occurs within the first three years of life. Individuals who are diagnosed with autism may exhibit some of the following characteristics, which can range in intensity from mild to severe and in various combinations: difficulty expressing needs; a preference towards solitude; a tendency towards tantrums; difficulty with socialization; making little or no eye contact; having an inappropriate attachment to objects; an over- or under-sensitivity to pain; not recognizing danger; exhibiting strange play; and unresponsiveness to normal teaching methods and/or verbal cues. Many children with autism also have varying degrees of intellectual disability.

ASPERGER'S SYNDROME

Asperger's syndrome is characterized by poor coordination and concentration, a restricted range of interests, and/or difficulty with social relationships. In Asperger's syndrome, cognitive and communicative development is within the normal or near-normal range in the first years of life. Individuals who are diagnosed with Asperger's syndrome have normal intelligence and adequate vocabulary and grammar skills. Also, these individuals often have unusual interests, which they pursue with great intensity.

RETT SYNDROME

Rett syndrome, which was first diagnosed in 1966 by Andreas Rett, is a neurologic disorder that is diagnosed primarily in females. Children with Rett syndrome develop normally for the first 6 to 18 months. However, changes in behavior and a regression or loss of gross motor skills (e.g., walking, moving), the ability to speak, and using hands purposefully begin to manifest themselves. Children with Rett syndrome tend to exhibit the repetition of meaningless gestures, such as constant hand-washing or hand-wringing.

CHILDHOOD DISINTEGRATIVE DISORDER (CDD)

CDD resembles autism but differs in that after a prolonged period of normal development (two to four years), the child begins to lose interest in the social environment, language, toileting, and self-care abilities. The etiology of CDD is unknown; however, some evidence suggests that it may occur as a result of some form of central nervous system pathology. Children with CDD have an increased risk of seizures and develop many features consistent with autism disorder.

PERVASIVE DEVELOPMENTAL DISORDER - NOT OTHERWISE SPECIFIED (PDD-NOS)

A diagnosis of PDD-NOS is most often made when a child experiences problems with social interaction and/or other areas (e.g., verbal and nonverbal communication skills) that are consistent with a diagnosis of ECDD or when stereotyped behavior, interests, and activities are present. Generally, children are three to four years old when they start exhibiting symptoms that lead parent(s) and/or caregiver(s) to seek a diagnosis.

Children diagnosed with PDD-NOS do not follow a set pattern of symptoms. A child is often diagnosed with PDD-NOS if he/she exhibits behavioral characteristics that are consistent with autism but does not meet the full *DSM-IV-TR* criteria for autism disorder.

INFANTILE CEREBRAL PALSY

Cerebral palsy is caused by malformation or damage to the brain, usually during pregnancy, but occasionally during delivery, or immediately after birth. Premature birth is associated with an increased risk of cerebral palsy. An infant may also get cerebral palsy from very severe jaundice after birth, or later during infancy from an injury or illness affecting the brain. Children with cerebral palsy have difficulty with bodily movement and muscle tone. The motor disability can vary from mild and barely noticeable to very profound. A child with cerebral palsy may simply be a little clumsy or awkward, or may be unable to walk. Some children have weakness and poor motor control of one arm and one leg on the same side of the body. Many have problems with paralysis of both upper and lower extremities. In some children the muscle tone generally is increased, while others are abnormally limp. While many of these children understand spoken language, their ability to produce speech may be affected.

INTELLECTUAL DEVELOPMENTAL DISORDER

Intellectual disability is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social and practical domains. The following three criteria must be met:

- A. Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.
- B. Deficits in adaptive functioning that result in failure to meet developmental and socio-cultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.
- C. Onset of intellectual and adaptive deficits during the developmental period.

EVALUATION

Early identification of ECDD is important because it allows early intervention, etiologic investigation, and counseling regarding recurrence risk and improved overall outcomes.

To identify individuals with ECDD, a comprehensive evaluation should include historical information such as a review of pregnancy, labor, delivery, early neonatal course, developmental history, and communicative and motor milestones. The medical history should include screening for sensory deficits (e.g., hearing or visual

impairments), as well as a discussion about other medical conditions and specific signs and symptoms. The history and physical examination may assist in the search for known etiologic or associated conditions. Other identified conditions may accompany ECCD including, but not limited to:

- **Seizures**
- **Sensory problems**
Sensory problems result from the inability to balance the senses appropriately. Many individuals with ECCD are highly attuned or even painfully sensitive to certain sounds, textures, tastes, and smells.
- **Intellectual disability**
Intellectual disability is a behaviorally defined disorder of complex human abilities with many genetic and nongenetic causes.
- **Fragile X syndrome (FXS)**
FXS is the most common form of inherited intellectual disability. It is caused by a mutation in a Fragile X Mental Retardation 1 [FMR1] gene.
- **Tuberous sclerosis complex (TSC)**
TSC is a genetic disorder that causes benign tumors to form in the brain and other vital organs. The disorder is characterized by hypopigmented macules on the skin, which are visualized on Wood's lamp examination. Some individuals with TSC experience developmental delays, intellectual disability, and autism.
- **Angelman syndrome (AS)**
AS is a neurodevelopmental disorder that is caused by a deficiency of a maternally transmitted gene. AS can be detected with fluorescent in situ hybridization [FISH] testing. AS is characterized by severe intellectual disability, ataxia, and a happy social disposition.

SCREENING/DIAGNOSTIC SERVICES

SCREENING TOOLS

The American Academy of Pediatrics (AAP) recommends that developmental surveillance should be incorporated at every well-child preventive care visit, and any concerns raised by surveillance should be addressed through standardized developmental screening tests. AAP recommends that an autism-specific screening tool should be administered to all children at the 18 and 24 or 30-month well-child visits, since symptoms of ECDD are often present at these ages, and effective early intervention strategies are available.

DIAGNOSTIC TOOLS

Healthcare professionals involved in diagnosing ECDD must be knowledgeable and experienced with comprehensive standardized diagnostic tools. Diagnostic tools include parent and/or caregiver reports, as well as observational diagnostic instruments (e.g., Autism Diagnostic Observation Schedule [ADOS], Autism Diagnostic

Interview-Revised [ADI-R], Childhood Autism Rating Scale [CARS]). It is also stressed that professionals involved in diagnosing ECDD must be knowledgeable and experienced in using guidelines.

ELECTROENCEPHALOGRAM (EEG)

EEGs are obtained when the individual has clinical suggestions of an associated condition, such as a seizure disorder or a degenerative condition.

AUDIOLOGIC, SPEECH, AND LANGUAGE EVALUATION

Audiologic evaluation and comprehensive speech and language evaluation should always be performed in any child who has language delays. The literature has documented that conductive, sensorineural, or mixed hearing loss can occur.

LABORATORY EVALUATION

Currently there is no laboratory test specific for ECDD. Laboratory evaluations may be indicated in children with suspected ECDD to determine an associated condition. For example, the National Center for Environmental Health of the Centers for Disease Control and Prevention recommends that children with developmental delays and pica, who may spend a prolonged period in the oral stage, be screened for lead poisoning. Additionally, quantitative plasma amino acid assays should be considered even if the findings from the neonatal screen for phenylketonuria were negative.

GENETIC COUNSELING

The recurrence rate of idiopathic ECDD is significant in siblings (5 to 10 percent) of affected children, it is important to provide genetic counseling after a diagnosis of ECDD to offer parents information about recurrence risks in subsequent children.

GENETIC TESTING

Research has identified various genetic disorders associated with ECDD; however, the total number of individuals with ASD who have a known genetic condition is only a small percentage of the whole. Conventional genetic testing methods to identify associated conditions of ECDD may include G-banded karyotyping and/or fluorescent in situ hybridization (FISH).

Despite the profusion of investigations into the genetic component of ECDD, many genetic tests that have been proposed for ECDD have yet to be validated by appropriate clinical studies. For example, comparative genomic hybridization (CGH) microarray is a molecular karyotyping method that increases the chromosomal resolution for the detection of genetic abnormalities. However, at this time, there is a lack of available studies that support CGH microarray testing for developmental delay, ASD, and/or intellectual disability.

Furthermore, due to the heterogeneity of ECDD, the multiple etiologies, and the questionable clinical validity of extensive screening tests of all children with ECDD,

additional evidence is needed before genetic testing of this population becomes standard of care. The AAP recommendation for routine clinical care is to limit extensive genetic testing to those with a suspicious family or medical history for a genetic condition associated with ECDD, intellectual disability, and/or dysmorphic features (e.g., facial, limb, stature).

MANAGEMENT

According to the National Institute of Child Health and Human Development, currently there is no definitive, single treatment for the management of ECDD. Individuals with ECDD have a wide spectrum of behaviors and abilities so that no one approach is equally effective for all, and not all individuals in outcome studies have benefited to the same degree. In addition, individuals with ECDD may require new and/or multiple episodes of care or modifications to the frequency and duration of existing services. These changes are typically based on re-examination due to the severity of the current condition, as well as changes related to growth and development, caregivers, environment, or functional demands.

The primary goals of management of ECDD are to minimize the core features and associated deficits, maximize functional independence and quality of life, and alleviate family distress (Myers et al, 2007). The management of ECDD may also include services such as, but not limited to:

PHARMACOLOGICAL MANAGEMENT

A consensus on the recommended guidelines for the use of medication in the management of ECDD has not been reached. Currently, the US Food and Drug Administration (FDA) has not approved any medications specifically for the treatment of ECDD. However, medications may be used to treat some of the symptoms associated with ASD (e.g., aggression, hyperactivity, inattention, depression, anxiety). The FDA has approved risperidone (Risperdal®) for the symptomatic treatment of irritability including aggression, deliberate self-injury, and temper tantrums in children and adolescents, ages five to sixteen, with ASD.

PHYSICAL THERAPY

Physical therapy is a medically prescribed treatment for physical disabilities or impairments that result from disease, injury, congenital anomaly, and/or prior therapeutic intervention. Features of ECDD may include delays in the achievement and advancement of motor skills and sensorimotor adaptation, atypical postures and movement patterns, deficient balance reactions, decreased muscle performance and range of mobility, and a general lack of physical fitness. Associated conditions may include, but are not limited to: hypotonia, limb apraxia, and joint laxities.

OCCUPATIONAL THERAPY

Occupational therapy practitioners work with individuals with ECDD, as well as parents, caregivers, educators, and other team members in a variety of settings, including the home, school, clinic, and community to assist the individual with successful participation and adaptation in school, home, and social environments.

According to the American Occupational Therapy Association (AOTA), goals for young individuals with ECDD frequently focus on enhancing an individual's sensory processing, sensorimotor performance, social/behavioral performance, self care, and participation in play. In older individuals with ECDD, occupational therapy goals focus on social/behavioral performance, activities of daily living, and independence in the community.

SPEECH THERAPY

Speech therapy is the medically prescribed treatment for speech and language disorders due to disease, surgery, injury, congenital anomalies, speech/language delay, or previous therapeutic processes that result in communication disabilities and/or swallowing disorders. According to the American Speech-Language-Hearing Association (ASHA), speech-language pathologists play a role in screening, diagnosing, and enhancing the development of social communication and quality of life of children, adolescents, and adults with ECDD. They work with individuals to help diagnose and treat specific speech and language deficits as well as related feeding disorders. There is no single approach that is equally effective for all individuals with ASD, and based on outcome studies, not all individuals benefit to the same degree. Speech-language consultative services should be aimed at helping the communicative partner (e.g., teacher, parent, caregiver, peer, and sibling) to provide the support and employ specific teaching strategies to enhance active engagement in natural learning environments.

PSYCHIATRIC SERVICES

Direct or consultative services are provided by a physician who specializes in psychiatry to diagnose ECDD and/or to diagnose and treat co-morbid psychiatric disorders that are exhibited by the individual with ECDD.

PSYCHOLOGICAL SERVICES

Direct or consultative services are provided by a psychologist to diagnose ASD and/or to diagnose and treat co-morbid psychological disorders that are exhibited by the individual with ASD.

APPLIED BEHAVIOR ANALYSIS (ABA) AND OTHER METHODOLOGIES TO PROMOTE LEARNING

Methodologies to promote learning are believed to enhance communication, teach social skills, and reduce maladaptive behaviors. These methodologies are based on several model programs including behavioral, structured teaching, and/or developmental.

Among the many methodologies available for the management of ECDD, ABA is arguably the most studied treatment modality in the field. It is generally believed that ABA is the process of applying interventions that are based on the principles of learning (e.g., positive reinforcement) derived from experimental psychology research to systematically change behavior. It can also be used to teach new skills and demonstrate that the interventions used are responsible for the observable

improvements in behavior. ABA methods are reportedly used to replace maladaptive, interfering behaviors with more desirable adaptive ones and to narrow the conditions under which these behaviors occur. In addition, ABA is believed to teach new skills through implicit instruction and repetition, generalize behaviors to new environments or situations, and maintain learned behaviors. For example, clear instruction with assistance (e.g., demonstration, prompting) is given to the individual. When the individual gives a correct response, the instructor gives positive reinforcement.

Components of ABA may include the following:

- An initial assessment through observations that focus on strengths and weaknesses of the individual
- Individualized treatment goals that are guided by the data from the initial assessment and are defined in observable terms
- A written treatment plan or set of instructions for teaching each behavior and/or skill, developed by a healthcare provider
- Training for the individual's parent(s) and/or caregiver(s) to implement the treatment plan consistently both within and outside formal treatment sessions
- A curriculum that focuses on all of the following:
 - Breaking down skills into manageable pieces
 - Building upon skills so that an individual can learn in a natural environment
 - Teaching the individual to combine skills acquired in more complex ways
- Documented frequent assessments of the individual's progress, using direct observational measurement methods with verification by secondary observers. As progress is made, guidance is systematically reduced
- No reinforcement for problem behaviors

There are many techniques used within the realm of ABA. Common techniques include, but are not limited to, the following:

- Discrete trial training (DTT) is behaviorally based instruction that involves rewarding performances of desired behaviors and completion of tasks with tangible positive reinforcement (e.g., food, toys) paired with social praise. The therapist-directed instruction may be repeated over several days until the skill is mastered. These skills are then combined into more complex repertoires.
- Pivotal response training is naturalistic behavioral intervention that is child-directed, and interventions are designed around materials or topics for which the individual expresses preference. Reinforcement is directly related to the task.
- Incidental teaching is behaviorally based instruction where the interaction between adult and child occurs in the context of a natural situation where the child expresses an interest in something and the adult responds with prompts and praise.

Competency for behavior analyst practitioners to perform services related to ABA can be demonstrated through the completion of specialized training. Organizations offer voluntary credentialing programs for behavior analyst practitioners (e.g., Behavior Analyst Certification Board (BACB) in an effort to provide consistent credentialing).

Some methodologies to promote learning have also emerged, and although they are not considered behavioral, they share common elements with behavioral methodologies. For example, the Treatment and Education of Autistic and Related Communication-Handicapped Children (TEACCH) model of structured teaching uses many forms of visual supports, such as picture schedules, to assist individuals with ECDD. Another modality commonly used with individuals is the developmental approach. Examples of the developmental approach include, but are not limited to, the Denver model (which focuses on intensive teaching and developing social communicative skills) and/or the developmental, individual-difference, relationship-based (DIR) floor-time model (which focuses on building emotional reciprocity). Despite the common use of such methodologies to promote learning, most have not been empirically validated.

A review of the available published peer-reviewed literature on ABA and other similar methodologies has revealed weaknesses in research design and analysis, as well as inconsistent results across studies, which undermine confidence in the reported results. Although it has been suggested that these methodologies may assist in the management of conditions associated with ASD, and many interventions including ABA have been endorsed by AAP, it is implicitly recognized that further high-quality studies are needed to determine the efficacy of these methodologies.

NEUROPSYCHOLOGICAL TESTING (NPT)

NPT consists of the administration of a series of standardized tests of differing mental functions and the interpretation of the findings so that inferences about brain function can be made. There is insufficient peer-reviewed literature to support standard use of NPT for individuals with ECDD; however, NPT may be helpful in evaluating specific neurologic conditions that are present in an individual with suspected ECDD. (Please see BCBSVT Policy on Neuropsychological Testing)

ALTERNATIVE THERAPIES AND COMPLEMENTARY MEDICINE

Since ECDD and ASD are chronic disorders that have no cure, parent(s) and/or caregiver(s) sometimes turn to alternative therapies and complementary medicine and/or therapies that are not traditionally used in the management of ECDD. Alternative therapies and complementary medicine comprise a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine. The following examples of alternative therapies and complementary medicine may be considered for the management of ECDD:

- **Nutritional supplements**

Proponents of nutritional supplements claim that high doses of pyridoxine and magnesium have beneficial effects on the symptoms of ECDD. However, studies have been criticized for their methodological shortcomings and failure to address the issue of safety of use.

- **Elimination diets**

Advocates of elimination diets have proposed that the selective absorption of ingested peptides caused by impaired bowel permeability can potentiate symptoms of ECDD. This has led to the conclusion that the elimination of casein (the principal protein in milk) and gluten (a composite of proteins found in rye, wheat, and barley) from a child's diet would improve behavioral symptoms. To date, only a small number of children on elimination diets have been studied, and no control group was provided. The efficacy and safety of elimination diets have not been established; therefore, this therapy lacks validation.

OTHER THERAPIES/TREATMENTS FOR THE MANAGEMENT OF ECDD

- **Immune globulin therapy**

Immune globulin therapy (IVIg) focuses on immunological abnormalities, such as abnormalities of T- and B-cells (specialized defender cells that identify and destroy germs). At the present time, there is no scientific evidence to support the use of IVIg injections for the treatment of children with ECDD.

- **Secretin**

Secretin is one of the hormones that control digestion. The primary action of secretin is to increase the volume of bicarbonate content of secreted pancreatic juices. The use of secretin in the treatment of ECDD comes from the theory that a link exists between gastrointestinal disorders and brain dysfunction. However, the available published literature does not support the use of secretin in the treatment of autism. In addition, the FDA has not approved the use of secretin in the treatment of autism.

- **Chelation therapy**

Intravenous (IV) chelation therapy is a method of removing toxic substances (e.g., lead, zinc, iron, copper, or calcium) from the body. Advocates of chelation therapy believe that ASD is caused by early childhood exposure to environmental toxicants, principally metals (particularly mercury in vaccines), and minerals. Studies have been unable to establish a connection between exposure to mercury and an incidence of ECDD. Therefore, no data exists on the efficacy of chelation therapy for the treatment of ECDD.

- **Auditory integration training (AIT)**

AIT is based on the unproven theory that ECDD symptoms are caused by auditory perception defects. AIT consists of the identification of hypersensitivity and peak of sound distortion, as well as the selection of the optimum music for the individual. Once these determinations are made, the selected music is played twice a day for two weeks through a listening device such as the AudioKinetron. The data from the available studies on AIT showed no improvement in behavior, leading to the conclusion that AIT is not efficacious in the treatment of ECDD. (Please see BCBSVT Policy on Physical Therapy)

- **Facilitative communication (FC)**

FC provides assistance to a nonverbal person in typing out words using a computer keyboard or other communication device. FC involves a trained facilitator supporting the individual's hand to help indicate which letters are necessary. Several scientific studies have suggested that facilitators unintentionally influence the communication, perhaps to the extent of actually selecting the words themselves. There are good scientific data showing FC to be ineffective.

- **Hippotherapy**

The available published literature does not support the use of hippotherapy in the treatment of ECDD. (Please see BCBSVT Policy on Physical Therapy and BCBSVT Policy on Hippotherapy)

- **Music Therapy**

The available published literature does not support the use of music therapy in the treatment of ECDD.

Policy

The intent of this policy is to communicate the medical necessity criteria for the evaluation and management of early childhood developmental disorders (ECDD), specifically autism spectrum disorders (ASD), in children diagnosed with early childhood developmental delay, from birth to age 21. Please see Attachment I for specific coding information.

To qualify for benefits, the member must be between the ages of birth to 21 years and follow the steps outlined below:

EVALUATION OF Early Childhood Developmental Disorders (ECDD)

The services listed below are the most frequently used components of an ECDD evaluation and are considered medically necessary:

- Review of the pregnancy, delivery, and early neonatal course
- Parent(s) and/or child interview, including any siblings
- Complete history and physical examination of the affected individual
- Developmental screening for ECDD using standardized developmental screening tool(s)
- Electroencephalogram (EEG)
 - If the individual has an associated seizure disorder, suspicion of subclinical seizure, or a developmental degenerative condition (e.g., a clinically significant loss of social and communicative function), an EEG may be performed.
- Audiologic and/or vision evaluation
 - If the individual has a hearing impairment and/or an associated language/developmental delay, an audiologic and/or vision evaluation may be performed.

- Speech, language, and/or communication evaluation
 - If the individual has a speech, language, and/or communication delay, and/or sensory-motor symptoms that interfere with feeding, an assessment by a speech-language pathologist may be performed.
- High-resolution chromosome studies (karyotype) and deoxyribonucleic acid (DNA) analysis for fragile X syndrome (FXS), may be performed if the individual has any of the following:
 - intellectual disability (or if intellectual disability cannot be excluded)
 - A family history of FXS or undiagnosed intellectual disability
 - Dysmorphic features (e.g., facial, limb, stature)
- Genetic counseling for parents of a child with ECDD regarding recurrence risk in subsequent children
- Laboratory evaluation as indicated, including the following:
 - Measurement of blood lead level
 - Quantitative plasma amino acid assays to detect phenylketonuria (a rare cause of ECDD and intellectual disability)

MANAGEMENT OF ECDD

PHYSICAL, OCCUPATIONAL, AND/OR SPEECH THERAPY

In accordance with the terms defined in the member's Certificate of Coverage on these topics, or where a state mandate provides for such coverage, physical, occupational, and/or speech therapy is considered medically necessary and, therefore, covered when all of the following criteria are met:

- The individual has a documented diagnosis in the International Classification of Diseases (ICD) or *Diagnostic and Statistical Manual of Mental Disorders (DSM-V™)* of:

Autism Disorders- 299.00 to 299.01

Childhood Disintegrative Disorder- 299.10 to 299.11

Asperger's Syndrome- 299.80 to 299.81

Unspecified Pervasive Developmental Disorder, Not otherwise specified- 299.90 to 299.91

Other Specified Cerebral Degenerations in Childhood (Rett's Syndrome) - 330.8

Infantile Cerebral Palsy-

Diplegic- 343.0

Hemiplegic- 343.1

Quadriplegic- 343.2

Monoplegic- 343.3

Infantile hemiplegia- 343.4

Intellectual Disability-

Moderate intellectual disability- 318.0

Severe- intellectual disability- 318.1

Profound intellectual disability- 318.2

- The individual has a history of a clinically significant impairment that interferes with the ability to negotiate their environment, communicate, learn, and/or

demonstrate appropriate social behavior, which may include any of the following:

- Impaired motor skills and/or musculoskeletal system involvement
- Impaired activities of daily living
- Impaired speech, language, and/or communication
- The parent(s) and/or caregiver(s) are willing and able to participate and follow the training and support that is incorporated into the treatment plan.
- The therapy is rendered by or under the direction of a healthcare provider who is appropriately licensed to perform the therapy and who is eligible under the terms of the member's benefit contract.
- The individual's progress in meeting the objectives of the treatment plan is measured on an ongoing basis for adjustment or refinement.

A comprehensive evaluation is required and must be submitted in order to obtain prior authorization for PT, OT, and ST services for members diagnosed with ECDD. The comprehensive evaluation does not require prior authorization, but ALL proposed PT, OT, and ST services pursuant to the comprehensive evaluation require prior authorization in order to determine medical necessity.

The benefit for PT, OT, and ST services for these conditions are not subject to a visit limit as outlined in the Member's Certificate of Coverage on Physical Therapy, Occupational Therapy and Speech Therapy. Vermont S.223 Act mandates coverage for therapies without set limitations as long as such therapies meet criteria for medical necessity. When coverage for such therapies is authorized, unless a provider or the Plan determines an earlier assessment is required, the assessment of the individual's progress in meeting the objectives of the treatment plan shall be valid for six (6) months. A treatment plan for children under age eight will occur no more frequently than once every six months. In order for benefits for PT, OT, or ST to continue beyond the initial 6 month period (or sooner if determined in the initial authorization), the provider must submit a progress report containing all applicable information outlined in the "Physician Documentation Information" section within this medical policy. Based on the information submitted, authorization for additional services may be extended for up to an additional six month period if such services are determined to be medically necessary.

Authorization for continued PT, OT, and/or ST services will not be granted if any of the following circumstances exist:

- Treatment is making the symptoms or negative behavior(s) persistently worse.
- No meaningful, measurable change has been documented in the individual's functioning and/or behavior(s) for a period of three months of optimal treatment.
 - Changes must be sustained over time beyond the end of the actual treatment session and can be generalized outside of the treatment setting to the individual's residence and to the larger community within which the individual resides.
- The individual has achieved adequate stabilization of functions and/or the challenging behavior(s), and less-intensive modes of therapy are appropriate.

- It is appropriate to restart treatment if measurable deterioration in functioning and/or behavior(s) occurs with less-intensive modes of therapy.
- The individual's parent(s) and/or caregiver(s) demonstrate adequate skill in administering a long-term home-based program.
- The individual demonstrates an inability to maintain long-term gains from the proposed treatment plan.

PSYCHIATRIC AND/OR PSYCHOLOGICAL SERVICES

Contact Vermont Collaborative Care at 1-800-922-8778 for psychiatric and/or psychological services eligible for coverage in individuals with ECDD.

APPLIED BEHAVIOR ANALYSIS (ABA) AND/OR OTHER METHODOLOGIES TO PROMOTE LEARNING

Contact Vermont Collaborative Care at 1-800-922-8778 for ABA and/or other services to promote learning that are eligible for coverage in individuals with ECDD.

In accordance with state mandate requirements effective October 1, 2012 for members enrolled in the Plan's commercial products, ABA is covered for the management of ECDD.

To view the medically necessary criteria for ABA and/or other related structured behavioral services, members enrolled in Vermont's commercial products and contracted with Vermont Collaborative Care for behavioral health/mental health management should contact Vermont Collaborative Care at 1-800-922-8778.

Refer to attachment 2, in this policy for reference documents of the Vermont State mandates regarding therapy for individuals with ECDD.

HABILITATIVE SERVICES

Habilitative and rehabilitative services are services provided to achieve normal functions and skills necessary to perform age-appropriate basic activities of daily living, including ambulation, eating, bathing, dressing, speech, and elimination.

Habilitation and rehabilitation services may include respiratory therapy, speech therapy, occupational therapy and physical medicine treatments. Habilitation and rehabilitation services may be performed by those who are qualified to perform such services and do so within the scope of their license. Such services are evaluated based on objective documentation of measurable progress toward functional improvement goals. Measurement methods must be valid, reliable, repeatable, and evidence-based.

Benefits for habilitation and rehabilitation services are available when the services are medically necessary and are covered benefits under the member's contract.

Habilitation is directed at achieving functions and skills that have not developed normally while rehabilitation is directed at restoring functions and skills lost due to disease, injury or other disabling condition.

The following services are not included and therefore not eligible under the scope of habilitation services: custodial care, vocational, recreational and educational services, or services that are considered maintenance in nature.

Additional treatment is not considered medically necessary in the absence of objective documentation of ongoing clinically significant functional improvement being achieved and when there is not a medically reasonable expectation that additional treatment will lead to additional clinically significant functional improvement.

NON COVERED SERVICES AND PROCEDURES:

- Services provided for the return to a sport or recreational activity.
- Services for general physical conditioning.
- Care for the purpose of holding at a steady state or preventing deterioration
- Care that is not expected to significantly improve the condition
- Care to improve overall fitness or endurance.
- Non-skilled therapy, including routine, repetitive and reinforced procedures that do not require one-to-one intervention.
- Education, educational evaluation or therapy, therapeutic boarding schools, services that should be Covered as part of an evaluation for, or inclusion in, a Child's individualized education plan (IEP) or other educational program. (This exclusion does not apply to treatment of diabetes, such as medical nutrition therapy by approved participating Providers.)
- Cognitive training or retraining and educational programs, including any program designed principally to improve academic performance, reading or writing skills.

NEUROPSYCHOLOGICAL TESTING (NPT)

NPT is considered not medically necessary and, therefore, not covered for ECDD unless the individual has an associated neurologically based condition that requires such testing. In those instances, indicate the primary diagnosis code that represents the associated neurologically based condition. (See BCBSVT policy on Neuropsychological Testing)

ALTERNATIVE THERAPIES AND COMPLEMENTARY MEDICINE

Alternative therapies and complementary medicine (e.g., nutritional supplements, high doses of pyridoxine and magnesium, casein-free and gluten-free diets) are standard benefit contract exclusions for most of the Plan's products and are not eligible for reimbursement consideration.

EXPERIMENTAL/INVESTIGATIONAL SERVICES

The Plan considers the following to be investigational in the screening or treatment of Early Childhood Developmental Disorders because the safety and/or efficacy of these diagnostic services, therapies, and treatments when used in the management of ECDD

cannot be established by review of the available published peer-reviewed literature, and are NOT eligible for benefits. These include but are not limited to:

- Allergy testing (including, but not limited to, food allergy for gluten, casein, Candida and other molds)
- Array Comparative Genomic Hybridization (aCGH) testing
- Art therapy
- Chelation therapy
- Cognitive Rehabilitation
- Electronystagmography (in the absence of dizziness, vertigo, or balance disorder)
- Elimination diets
- Erythrocyte glutathione peroxides studies
- Facilitative communication [FC]
- Floor time therapy
- Holding therapy
- Hair Analysis for trace elements
- Hippotherapy
- Hyperbaric oxygen therapy
- Immune globulin therapy [IVIg]
- Intestinal permeability studies
- Magnetoencephalography
- Music therapy and rhythmic entrainment interventions
- Neuroimaging studies such as: CT, MRI, MRS, PET, SPECT, and Functional MRI (Please see BCBSVT Policy on Radiology)
- Nutritional, Mineral and Herbal Supplements (e.g., megavitamins, high dose pyridoxine and magnesium, dimethylglycine and glutathione, calcium, germanium, selenium, tin, tungsten, vanadium, zinc, echinacea, berberis, etc.)
- Secretin Infusions
- Sensory integration modalities including, but not limited to, Berard Auditory integration training [AIT]; The Audio Tone Enhancer/Trainer; Digital Auditory Aerobics; Electronic Auditory Stimulation effect (EASe program); Kirby Auditory Modulation System (KAMS); SAMONAS Sound Therapy; Tomatis Sound Therapy The LiFT™; The Listening Program
- Squeeze machine therapy
- Stool Analysis
- Tests for micronutrients (i.e., vitamin levels), urinary peptides, mitochondrial disorders including lactate and pyruvate, celiac antibodies, amino acids (except quantitative plasma amino acid assays to detect phenylketonuria), heavy metals, trace metals, immunologic or neurochemical abnormalities
- Tympanometry (in the absence of hearing loss)
- Vision Therapy

REQUIRED DOCUMENTATION

The individual's medical record must reflect the medical necessity for the care provided. These medical records may include, but are not limited to: records from the health care professional's office, hospital, nursing home, home health agencies,

therapies, and test reports.

The Plan may conduct reviews and audits of services to our members, regardless of the participation status of the provider. All documentation is to be available to the Plan upon request. Failure to produce the requested information may result in a denial for the service.

Documentation of the performing provider's qualifications must be made available to Plan upon request.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval is required. Limitations to this benefit apply. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy. Benefits are subject to all terms, limitations and conditions of the subscriber contract.

For New England Health Plan (NEHP) members an approved referral authorization is required.

Federal Employee Program (FEP) members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP plan brochure.

State mandates and contractual exclusions may apply to coverage eligibility.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through a self-funded group, benefits may vary or not apply. To verify benefit information, please refer to the member's plan documents or contact the customer service department.

Prior Authorization is required for all therapeutic services (PT, OT, and ST, with the exception of the initial comprehensive evaluation) NOTE: Prior authorization is not needed for the initial screening and/or diagnostic assessments for ECDD.

All psychiatric and/or psychological services eligible for coverage in individuals with ECDD must be prior authorized by Vermont Collaborative Care by calling 1.800.922.8778.

Subject to the terms and conditions of the applicable benefit contract, evaluation for Early Childhood Developmental Disorders (ECDD) is covered under the medical benefits of the Plan's products when the medical necessity criteria in this medical policy are met or when state mandate(s) require coverage for such services. However, except where required by state mandate(s), services that are identified in this policy as

experimental/investigational or not medically necessary are not eligible for coverage or reimbursement by the Plan.

The provision of benefits for all services related to outpatient physical, occupational, and/or speech therapy is in accordance with the BCBSVT Medical Policy on PT, ST, and OT in Early Childhood Developmental Disorders (ECDD). Individual member benefits must be verified. Some services may be subject to state mandates, medical necessity criteria, precertification or preapproval, or existing contractual or policy exclusions.

Pharmacy services for ECDD are covered under the pharmacy benefits of the Plan's products. Individual benefits must be verified.

Management of ECDD may not routinely include psychiatric and/or psychological services for all individuals enrolled in a Plan product. For information about psychiatric and/or psychological services eligible for coverage in individuals with ECDD, contact Vermont Collaborative Care at or 1-800-922-8778.

TREATMENT PLAN DOCUMENTATION REQUIREMENTS

The individual's treatment plan must document all of the following:

- Significant history
- Diagnosis of ECDD and rationale for requiring services
- Any related physician's orders
- The goals for the services, which must be:
 - Specific and measurable
 - Individualized
 - Updated on a frequent basis
 - Based on the individual's progress
 - To improve function and/or behavior significantly
 - To prevent loss of attained skill or function and/or produce socially significant improvement in human behavior (reduce interfering behaviors)
- Type, amount, duration, and frequency of services
- Direct observation, measurement, and functional analysis of the relations between environment and behavior
- Interventions such as, but not limited to, physical, occupational, speech therapy and/or ABA that are consistent with current techniques and standards
- Any contraindications to a course of services
- Parent(s)' and/or caregiver(s)' awareness and understanding of the diagnoses, prognoses, and goals of services
- When appropriate, a summary of past services and the results that were achieved
- Reasonable expectation, based on the individual's clinical history, that withdrawal of treatment will result in the decompensation or the recurrence of signs and symptoms

In order for claims to process correctly for PT, OT and ST services in Early Childhood Developmental Disorders (ECDD), diagnosis codes specific to ECDD must be listed as the *primary* diagnosis code. Please see Attachment I for specific coding information.

DOCUMENTATION FOR DATES OF SERVICE

Treatment and modality notes for dates that services are provided and billed for must include the following documentation:

- Date of service
- Specific service provided
- If modalities are utilized, documentation of the length of time spent in each modality
- If exercises or equipment are utilized, documentation of the specific activity, time, and/or number of repetitions
 - Exercises or modalities that require therapist supervision should be supported with an indication of the time spent and the level of skill required by the individual
- The individual's response to the service
- Skilled, ongoing reassessment of the individual's progress towards established goals
- Objective, measurable, and specific documentation of progress towards goals using consistent and comparable methods
- Changes to the treatment plan or objective reasoning for why the individual has not progressed towards goals
- Name and credentials of the treating clinician

Eligible Providers

Medical Doctor-MD
Doctor of Osteopathy-DO
Occupational Therapists-OT
Physical Therapists-PT
Licensed Speech Language Pathologists-LSLP
Clinical Psychologists - PhD
Licensed Clinical Social Workers-LCSW
Applied Behavioral Analysts
Assistant Applied Behavioral Analysts
Naturopaths-ND

Related Policies

Array Comparative Genomic Hybridization (aCGH)
Occupational Therapy
Physical Therapy
Speech Therapy
Pediatric Neurodevelopmental Testing
Neuropsychological Testing
Hippotherapy

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non-compliant payments.

Legislative Guidelines

8 V.S.A. § 4088i Early Childhood Developmental Disorders.

Policy Implementation/Update information

New Policy 7/2011

Revised for internal use 2/2012

Revised 9/2012- Vermont State Mandate S.223 (See Attachment 2). CPT changes, ICD-9 changes. Audit Information section and Legislative Guidelines section added. Pg 14- Autism Policy effective and term dates (upon renewal will have ECDD) referenced. Medical/Coder reviewed RLJ.

11/2013- Addition of diagnoses: Cerebral palsy and Intellectual disability and all ICD codes included in original Autism medical policy. Age changed to 21 years. ICD-10 remediated. IEP and Academic improvement exclusion added to pg. 15.

Scientific Background and Reference Resources

1. American Academy of Neurology (AAN) and the Child Neurology Society. Practice parameter: Screening and diagnosis of autism. [AAN Web site]. August 2000. Available at: <http://www.aan.com/professionals/practice/pdfs/gl0063.pdf>. Accessed October 28, 2009.
2. American Academy of Pediatrics (AAP). Auditory integration training and facilitated communication for autism. [AAP Web site]. Original: August 1998. (Reaffirmed: 05/01/06). Available at: <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;102/2/431>. Accessed October 28, 2009.
3. American Academy of Pediatrics (AAP). Technical report: the pediatrician's role in the diagnosis and management of autistic spectrum disorder in children. [AAP Web site]. May 2001. Available at: <http://pediatrics.aappublications.org/cgi/reprint/107/5/e85>. Accessed October 28, 2009.
4. American Psychiatric Association. Pervasive development disorders. In: First MB, ed. *Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition - Text Revision (DSM-IV-TR™)* 4th ed. Arlington, VA: American Psychiatric Publishing, Inc.; 2000: 69-84.
5. American Speech-Language-Hearing Association (ASHA). Guidelines for speech-language pathologists in diagnosis, assessment, and treatment of autism spectrum disorders across the life span. [ASHA Web site]. 02/03/06. Available at: <http://www.asha.org/docs/html/gl2006-00049.html>. Accessed October 28, 2009.
6. Behavior Analyst Certification Board (BACB). About BACB. [BACB Web site]. 2009. Available at: http://www.bacb.com/cues/frame_about.html. Accessed October 28, 2009.

7. Centers for Disease Control and Prevention (CDC). Fragile X syndrome. [CDC Web site]. 09/01/06. Available at: http://www.cdc.gov/ncbddd/single_gene/fragilex.htm. Accessed October 28, 2009.
8. Centers for Disease Control and Prevention (CDC). Mental health in the United States: parental report of diagnosed autism in children aged 4-17 years - United States, 2003-2004. [CDC Web site]. 05/05/06. Available at: <http://www.cdc.gov/MMWR/preview/mmwrhtml/mm5517a3.htm>. Accessed October 28, 2009.
9. Centers for Disease Control and Prevention (CDC). Prevalence of the autism spectrum disorders in multiple areas of the United States, surveillance years 2000 and 2002. [CDC Web site]. 03/11/09. Available at: <http://www.cdc.gov/ncbddd/dd/addmprevalence.htm>. Accessed October 28, 2009.
10. Fombone E. Prevalence of childhood disintegrative disorder. *Autism*. 2002;6(2):149-157.
11. Jobe TH, Gavira M, Kovilparambil A, eds. *Clinical Neuropsychiatry*. Malden, MA: Blackwell Science, Inc.; 1997.
12. Johnson CP, Myers SM, American Academy of Pediatrics (AAP) Council on Children with Disabilities. Clinical report: identification and evaluation of children with autism spectrum disorders. *Pediatrics*. 2007;120(5):1183-1215. Also available on the AAP Web site at: <http://pediatrics.aappublications.org/cgi/reprint/120/5/1183>. Accessed October 28, 2009.
13. Lowe TL, Tanaka K, Seashore MR, Young JG, Cohen DJ. Detection of phenylketonuria in autistic and psychotic children. *JAMA*. 1980;243(2):126-128. Also available on the Pub Med Web site at: <http://www.ncbi.nlm.nih.gov/pubmed/7350353>. Accessed October 28, 2009.
14. Muhle R, Trentacoste SV, Rapin I. The genetics of autism. *Pediatrics*. 2004;113(5):e472-e486. Also available on the American Academy of Pediatrics Web site at: <http://pediatrics.aappublications.org/cgi/reprint/113/5/e472>. Accessed October 28, 2009.
15. Myers SM, Johnson CP, American Academy of Pediatrics (AAP) Council on Children with Disabilities. Management of children with autism spectrum disorders. *Pediatrics*. 2007;120(5):1162-1182. Also available on the AAP Web site at: <http://pediatrics.aappublications.org/cgi/reprint/120/5/1162>. Accessed October 28, 2009.
16. National Conference of State Legislatures (NCSL). NCSL autism legislation database. [NCSL Web site]. Available at: <http://www.ncsl.org/programs/health/autism.htm>. Accessed October 28, 2009.
17. National Guideline Clearinghouse. Assessment, diagnosis and clinical interventions for children and young people with autism spectrum disorders. A national clinical guideline. [National Guideline Clearinghouse Web site]. July 2007. Available at: http://www.guideline.gov/summary/summary.aspx?doc_id=11011. Accessed October 28, 2009.
18. National Guideline Clearinghouse. Practice parameter: screening and diagnosis of autism. Report of the Quality Standards Subcommittee of the American Academy of Neurology and the Child Neurology Society. [National Guideline Clearinghouse Web site]. Original: August 2000. (Reaffirmed: July 2006). Available at:

- http://www.guideline.gov/summary/summary.aspx?doc_id=2822. Accessed October 28, 2009.
19. National Institute of Child Health and Human Development (NICHD). Autism overview. [NICHD Web site]. 05/03/05. Available at: <http://www.nichd.nih.gov/publications/pubs/autism/overview/index.cfm>. Accessed October 28, 2009.
 20. National Institute of Child Health and Human Development (NICHD). Rett syndrome. [NICHD Web site]. April 2006. Available at: http://www.nichd.nih.gov/publications/pubs/upload/rett_syndrome_2006.pdf. Accessed October 28, 2009.
 21. National Institute of Mental Health (NIMH). Introduction: Autism spectrum disorders (pervasive developmental disorders). [NIMH Web site]. 01/23/09. Available at: <http://www.nimh.nih.gov/health/publications/autism/introduction.shtml>. Accessed October 28, 2009.
 22. National Institute of Mental Health (NIMH). Autism spectrum disorders (pervasive developmental disorders). [NIMH Web site]. 02/05/09. Available at: <http://www.nimh.nih.gov/publicat/autism.cfm>. Accessed October 28, 2009.
 23. Tuberous sclerosis (TS) Alliance. Tuberous sclerosis and autism spectrum disorders. [TS Alliance Web site]. Available at: <http://www.tsalliance.org/Fact%20Sheets/TS%20and%20autism%20spectrum%20disorders.pdf>. Accessed October 28, 2009.
 24. US Food and Drug Administration (FDA). Center for Drug Evaluation and Research. SecreFlo™ (secretin) for injection. Approval letter. [FDA Web site]. 04/04/02. Available at: http://www.accessdata.fda.gov/drugsatfda_docs/applletter/2002/21136ltr.pdf. Accessed October 28, 2009.
 25. US Food and Drug Administration (FDA). FDA approves the first drug to treat irritability associated with autism, Risperdal. [FDA Web site]. 10/06/06. Available at: <http://www.fda.gov/bbs/topics/news/2006/new01485.html>. Accessed October 28, 2009.
 26. Volkmar FR, Rhea P, Klin A, Cohen DJ, eds. *Handbook of Autism and Pervasive Developmental Disorders*. Volumes I and II. 3rd ed. Hoboken, NJ: John Wiley & Sons, Inc.; 2005.
 27. Volkmar FR, Rutter M. Childhood disintegrative disorder: results of the DSM-IV autism field trial. *J Am Acad Child Adoles Psychiatry*. 1995;34(8):1092-1095.

Approved by BCBSVT Medical Directors

Date Approved

Spencer Borden MD
Chair, Medical Policy Committee

Robert Wheeler MD
Chief Medical Officer

Attachment I
ICD & CPT Code List & Instructions

Code Type	Number	Brief Description	Policy Instructions
This policy applies to the following diagnoses codes only			
ICD-9	299.00-299.01	Autism Spectrum Disorder	
ICD-9	299.10-299.11	Childhood Disintegrative Disorder	
ICD-9	299.80-299.81	Asperger's Disorder	
ICD-9	299.90-299.91	Unspecified Pervasive Development Disorder	
ICD-9	318.0	Intellectual Disability- Moderate	
ICD-9	318.1	Intellectual Disability- Severe	
ICD-9	318.2	Intellectual Disability- Profound	
ICD-9	330.8	Other Specified Cerebral Degenerations in Childhood (Rett's syndrome)	
ICD-9	343.0	Infantile Cerebral Palsy- Diplegic	
ICD-9	343.1	Infantile Cerebral Palsy- Hemiplegic	
ICD-9	343.2	Infantile Cerebral Palsy- Quadriplegic	
ICD-9	343.3	Infantile Cerebral Palsy- Monoplegic	
ICD-9	343.4	Infantile hemiplegia	
ICD-9	343.8	Other specified infantile cerebral palsy	
ICD-10	F71	Intellectual Disability- Moderate	Effective 10-1-14

ICD-10	F72	Intellectual Disability- Severe	Effective 10-1-14
ICD-10	F73	Intellectual Disability- Profound	Effective 10-1-14
ICD-10	F84.0	Autism Spectrum Disorder	Effective 10-1-14
ICD-10	F84.2	Rett's Syndrome	Effective 10-1-14
ICD-10	F84.3	Other Childhood Disintegrative Disorder	Effective 10-1-14
ICD-10	F84.5	Asperger's syndrome	Effective 10-1-14
ICD-10	F84.8	Other pervasive developmental disorders	Effective 10-1-14
ICD-10	F84.9	Pervasive developmental disorder, unspecified	Effective 10-1-14
ICD-10	G80.0	Spastic quadriplegic cerebral palsy	Effective 10-1-14
ICD-10	G80.1	Spastic diplegic cerebral palsy	Effective 10-1-14
ICD-10	G80.2	Spastic hemiplegic cerebral palsy also coded for: Infantile hemiplegia	Effective 10-1-14 maps to ICD-9 codes: 343.1 and 343.4
ICD-10	G80.8	Other Cerebral palsy also coded for: Monoplegia	Effective 10-1-14 maps to ICD-9 codes: 343.3 and 343.8
The following codes will be considered as medically necessary when applicable criteria have been met.			
		Applied Behavioral Analysis ABA	Refer to VCC for billing guidance
		Audiologic Evaluation	See BCBSVT policy on Evaluation of Hearing
		Outpatient Occupational Therapy	Requires Prior Authorization, with the exception of the initial comprehensive evaluation
		Outpatient Physical Therapy	Requires Prior Authorization, with the exception of the initial comprehensive evaluation
		Outpatient Speech Therapy	Requires Prior Authorization, with the exception of the initial comprehensive evaluation

		Vision Evaluation	See BCBSVT policy on vision services
CPT	83655	Lead	
CPT	84030	Phenylalanine (PKU) blood	
CPT	88245	Chromosome analysis for breakage syndromes; Baseline Sister Chromatid Exchange (SCE) 20-25 cells	
CPT	88248	Chromosome analysis for breakage syndromes; baseline breakage, score 50-100 cells, count 20 cells, 2 karyotypes (e.g., for ataxia telangectasia, Fanconi anemia, fragile X)	
CPT	88249	Chromosome analysis for breakage syndromes; baseline breakage, score 100 cells, clastogen stress (e.g., diepoxybutane, mitomycin C, ionizing radiation, UV radiation)	
CPT	88261	Chromosome analysis; count 5 cells, 1 karyotype, with banding	
CPT	88262	Chromosome analysis; count 15-20 cells, 2 karyotypes, with banding	
CPT	88263	Chromosome analysis; count 45 cells for mosaicism, 2 karyotypes, with banding	
CPT	88264	Chromosome analysis; analyze 20-25 cells	
CPT	95812	Electroencephalogram (EEG) extended monitoring; 41-60 minutes	
CPT	95813	Electroencephalogram (EEG) extended monitoring; > 1 hour	
CPT	95816	Electroencephalogram (EEG); including recording awake and drowsy	
CPT	95819	Electroencephalogram (EEG); including recording awake and asleep	

CPT	96040	Medical Genetics and Genetic Counseling services, each 30 minutes face-to-face with patient/family	
CPT	96110	Developmental screening, with interpretation and report, per standardized instrument form	
CPT	96111	Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report	
CPT	96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report	
CPT	97532	Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes	
HCPCS	H0032	Applied Behavioral Analysis (ABA) - Initial Assessment & Plan Development, per hour	
HCPCS	H2014	Supervision of ABA follow-up or Therapeutic Staff Support, per 15 minutes	
HCPCS	H2019	Supervision of ABA follow-up or Therapeutic Staff Support, per 15 minutes	

HCPCS	H2021	Applied Behavior Analysis (ABA) - Follow-up & Reassessment, per 15 minutes	
HCPCS	S0265	Genetic Counseling, under physician supervision, each 15 minutes	
HCPCS	S9128	Speech Therapy, in the home, per diem	
HCPCS	S9152	Speech Therapy re-evaluation	
The following codes will be denied as Not Medically Necessary			
CPT	96118	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	Will be denied as not medically necessary
CPT	96119	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face	Will be denied as not medically necessary
CPT	96120	Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report	Will be denied as not medically necessary
The following codes will be denied as Investigational or Experimental			

CPT	90283	Immune globulin (IgIV), human, for intravenous use	Will be denied as Investigational or Experimental
CPT	97039	Unlisted modality (specify type and time if constant attendance)/ Hippotherapy	Will be denied as Investigational or Experimental
CPT	97139	Unlisted therapeutic procedure (specify)/Auditory Integrative training or Facilitative communication	Will be denied as Investigational or Experimental
CPT	97139	Unlisted therapeutic procedure (specify)/Hippotherapy	Will be denied as Investigational or Experimental
CPT	97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes	Will be denied as Investigational or Experimental
CPT	97799	Unlisted physical medicine/rehabilitation service or procedure/Hippotherapy	Will be denied as Investigational or Experimental
CPT	99183	Physician attendance and supervision of hyperbaric oxygen therapy; per session	Will be denied as Investigational or Experimental
HCPCS	C1300	Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval	Will be denied as Investigational or Experimental
HCPCS	J1557	Injection, immune globulin, (Gammaplex), intravenous, non-lyophilized (e.g., liquid), 500mg	Will be denied as Investigational or Experimental
HCPCS	G0176	Activity Therapy such as music, dance, art, or play therapies, not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)	Will be denied as Investigational or Experimental

HCPCS	J0470	Injection, dimercaprol, per 100 mg (BAL in oil)	Will be denied as Investigational or Experimental
HCPCS	J0600	Injection, edetate calcium disodium up to 1,000 mg	Will be denied as Investigational or Experimental
HCPCS	J0895	Injection, deferoxamine mesylate, 500 mg (Desferal)	Will be denied as Investigational or Experimental
HCPCS	J1459	Injection, immune globulin (Privigen), intravenous, non-lyophilized (e.g. liquid), 500 mg	Will be denied as Investigational or Experimental
HCPCS	J1561	Injection, immune globulin, (Gamunex), intravenous, non-lyophilized (e.g., liquid), 500 mg	Will be denied as Investigational or Experimental
HCPCS	J1566	Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg	Will be denied as Investigational or Experimental
HCPCS	J1568	Injection, immune globulin, (Octagam), intravenous, non-lyophilized (e.g., liquid), 500 mg	Will be denied as Investigational or Experimental
HCPCS	J1569	Injection, immune globulin, (Gammagard liquid), intravenous, non-lyophilized (e.g., liquid), 500 mg	Will be denied as Investigational or Experimental
HCPCS	J1572	Injection, immune globulin, (Flebogamma/Flebogamma DIF), intravenous, non-lyophilized (e.g., liquid); 500 mg	Will be denied as Investigational or Experimental
HCPCS	J1599	Injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), not otherwise specified, 500 mg	Will be denied as Investigational
HCPCS	J2850	Injection, Secretin, synthetic, human, 1mcg	Will be denied as Investigational or Experimental
HCPCS	J3520	Edetate disodium, per 150 mg	Will be denied as Investigational or Experimental

HCPCS	M0300	IV chelation therapy	Will be denied as Investigational or Experimental
HCPCS	S3870	Comparative Genomic Hybridization (CGH) Microarray Testing	Will be denied as Investigational or Experimental
HCPCS	S8940	Equestrian /Hippotherapy, per session	Will be denied as Investigational or Experimental
HCPCS	S9355	Home infusion therapy, chelation therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, per diem	Will be denied as Investigational or Experimental
HCPCS	S9338	Home infusion therapy, immunotherapy, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	Will be denied as Investigational or Experimental
Revenue Code	0413	Hyperbaric oxygen therapy	Will be denied as Investigational or Experimental

Attachment 2

State Mandate on Early Childhood Developmental Disorders, including autism spectrum disorders is set forth in S.223, Provision Number 158.

COVERAGE FOR DIAGNOSIS AND TREATMENT OF Early childhood Developmental Disorders

(a) A health insurance plan shall provide coverage for the diagnosis and treatment of autism spectrum disorders, including applied behavior analysis supervised by a nationally board-certified behavior analyst, for children, beginning at 18 months of age and continuing until the child reaches age six or enters the first grade, whichever occurs first.

(b) A health insurance plan shall not limit in any way the number of visits an individual eligible for coverage under subsection (a) of this section may have with an autism services provider.

(c) A health insurance plan shall not impose greater coinsurance, co-payment, deductible, or other cost-sharing requirements for coverage of the diagnosis or treatment of autism spectrum disorders than apply to the diagnosis and treatment of any other physical or mental health condition under the plan.

(d) As used in this section:

(1) “Applied behavior analysis” means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior. The term includes the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(2) “Autism spectrum disorders” means one or more pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, pervasive developmental disorder not otherwise specified and Asperger’s disorder.

(3) “Behavioral health treatment” means evidence-based counseling and treatment programs, including applied behavior analysis, that are:

(a) Necessary to develop skills and abilities for the maximum reduction of physical and mental disability and for restoration of an individual to his or her best functional level, or to ensure that an individual under the age of 21 achieves proper growth and development;

(b) Provided or supervised by a nationally board-certified behavior analyst or by a licensed provider, so long as the services are performed are within the provider’s scope of practice and certifications.

(4) “Diagnosis of early childhood development disorders” means medically necessary assessments; evaluations; or tests to determine whether an individual has an early childhood developmental delay, including autism spectrum disorder.

(5) “Early childhood developmental disorder” means a childhood mental or physical impairment or combination of mental and physical impairments that results in functional limitations in major life activities, accompanied by a diagnosis defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Disease (ICD). The term includes autism spectrum disorders, but does not include a learning disability.

(6) “Evidence-based” means the same as in 18 V. S. A. 4621.

(7) “Health insurance plan” means Medicaid, the Vermont health access plan, and any other public health care assistance program, any individual or group health insurance policy, any hospital or medical service corporation or health maintenance organization subscriber contract, or any other health benefit plan offered, issued, or renewed for any person in this state by a health

insurer, as defined in 18 V.S.A. § 9402. The term does not include benefit plans providing coverage for specific diseases or other limited benefit coverage.

(8) “Medically necessary” Describes health care services that are appropriate in terms of type, amount, frequency, setting and duration to the individual’s diagnosis or condition, are informed by generally accepted medical or scientific evidence, and are consistent with generally accepted practice parameters. Such services shall be informed by the unique needs of each individual and each presenting situation, and shall include a determination that a service is needed to achieve proper growth and development or to prevent the onset or worsening of a health condition.

- (9) "Natural Environment" means a home or child care setting.
- (10) "Pharmacy Care" means medications prescribed by a license physician and any health-related services deemed medically necessary to determine the need for or effectiveness of a medication.
- (11) "Psychiatric Care" means direct or consultative services provided by a licensed physician certified in psychiatry by the American Board of Medical Specialties.
- (12) "Psychological Care" means direct or consultative services provided by a psychologist licensed pursuant to 25 V. S. A. chapter 55.
- (13) "Therapeutic care" means services provided by licensed or certified speech language pathologists, occupational therapists, or physical therapists.
- (14) "Treatment for early developmental disorders" means evidence-based care and related equipment prescribed, or ordered for an individual by a licensed health care provider or a licensed psychologist who determines the care to be medically necessary:
- (A) behavioral health treatment;
 - (B) pharmacy care;
 - (C) psychiatric care;
 - (D) psychological care; and
 - (E) therapeutic care.
- (G) Nothing in this section shall be construed to affect any obligation to provide services to an individual under an individualized family service plan, individualized education program, or individualized service plan. A health insurance plan shall reimburse services provided under 16 V. S. A. 2959a.
- (H) It is the intent of the general assembly that the department of financial regulation facilitate and encourage health insurance plans to bundle co-payments accrued by beneficiaries receiving services under this section to the extent possible.

Sec. 3. APPLICABILITY AND EFFECTIVE DATE

- (a) This act shall take effect on July 1, 2012 and shall apply to Medicaid, the Vermont health access plan, and any other public health care assistance program on or after July 1, 2012.
- (b) The provisions of this act shall apply to all other health insurance plans on or after October 1, 2012, on such date as a health insurer issues, offers, or renews the health insurance program, but in no event later than October 1, 2013.

Sec. 4. EVALUATION OF COVERAGE FOR SCHOOL-AGE CHILDREN; IDENTIFICATION OF SAVINGS AND EFFICIENCIES

- (a) The agencies of administration and of human services and the department of education shall evaluate the feasibility and budget impacts of requiring health insurance plans, including Medicaid and the Vermont health access plan, to provide coverage of autism spectrum disorders, including applied behavior analysis supervised by a nationally board-certified behavior analyst for children under the age of 18 who have been diagnosed with an autism spectrum disorder. The agencies and department shall also assess the availability of providers of services across Vermont for individuals with autism spectrum disorders. No later than January 15, 2011, the agencies and department shall report their findings and recommendations regarding expanding coverage of treatment for autism spectrum disorders to school-age children and the availability of providers to the house

committees on health care and on appropriations and the senate committees on health and welfare and on appropriations.

(b) In preparing their fiscal year 2012 budget proposals, the agencies of administration and of human services and the department of education shall collaborate to identify savings, reductions in spending trends, and avoided costs to be achieved by reducing duplications of effort and maximizing achievable efficiencies in the provision of services to children diagnosed with autism spectrum disorders. In addition, the agencies and the department shall estimate the amount of savings and avoided costs to be realized by the state over time as a result of the insurance coverage requirement in Sec. 2 of this act. The agencies and the department shall collaborate with the joint fiscal office and shall include in their fiscal year 2012 budget proposals all identified and projected savings, reductions in trend, and avoided costs that may be used to offset the state's share of expenditures resulting from the requirement that health insurance plans provide coverage for diagnosis and treatment of autism spectrum disorders.

(c) In order to permit the general assembly to assess the availability of sufficient funds to implement the coverage requirement established in Sec. 2 of this act in fiscal year 2012, no later than February 15, 2011, the agencies of administration and of human services and the department of education shall report to the house committees on health care and on appropriations and the senate committees on health and welfare and on appropriations the amount of savings, reductions in spending trends, and avoided costs they have identified pursuant to subsection (b) of this section that will offset the state's share of expenditures related to the coverage requirement.

(d) If the report required by subsection (c) of this section or the findings of the committees of jurisdiction indicate that sufficient funds will not be available to offset the state's share of expenditures related to the coverage requirement established in Sec. 2 of this act in fiscal year 2012, it is the intent of the general assembly to consider whether to proceed with implementation of such coverage requirement.

Approved: May 27, 2010