



Clinical Policy: Autism Spectrum Disorders: Diagnosis and Treatment

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[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

This document addresses screening and diagnostic evaluation and investigational services for Autism Spectrum Disorders (ASDs) and other pervasive spectrum disorders. NOTE: Applied Behavioral Analysis (ABA) is addressed in a separate Centene Clinical Policy on ABA.

Policy/Criteria

- I. It is the policy of Health Net of California that the following may be **medically necessary** to screen for autism spectrum disorders:
 - A. Screening for ASD should be performed as a part of routine well-baby checks and ongoing developmental monitoring. Primary care providers (PCPs) should screen all children from birth to age 5 for autism and other developmental delays by:
 - Assessing vision and hearing
 - Directly observing the child in structured and unstructured settings
 - Evaluating cognitive functioning (verbal and nonverbal)
 - Assessing adaptive functioning
 - Discussing with the parents any concerns they have, as they are usually the first to notice that something is not progressing as it should
 - Asking the parents direct questions regarding the child's functioning core symptoms of ASD, including social relatedness and repetitive or unusual behaviors(ref. # 3)
 - Educate parents that there may some children who are more intellectually able and whose social disability may not be detected until a later age(Ref. #3)
 - B. Screening assessment tools are available, and can be useful in determining the need for further evaluation and assessment, however they are not intended for sole use in making a diagnosis. Some screening tools include:
 - Pervasive Developmental Disorders Screening Test – II (PDDST-II) for children from birth to three years old
 - Checklist of Autism in Toddlers (CHAT) for 18-month-old children
 - Autism Behavior Checklist (ABC), completed by parents or caregiver
 - Childhood Autism Rating Scale (CARS), clinician-rated tool for use with children over two, evaluates body movements, adaptation to change, listening response, verbal communication and relatedness to people
 - Modified Checklist for Autism in Toddlers (M-CHAT) for two-year-olds
 - Screening Test for Autism in Two-Year-Olds (STAT)
 - Social Communication Questionnaire (SCQ) for children age four and over.



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- II. It is the policy of Health Net of California that the following may be **medically necessary** in the diagnostic evaluation for autism spectrum or pervasive developmental disorders:
- A. The diagnosis of ASD is based on a coordinated effort by a team of medical and behavioral health specialists working closely with the parents. The team generally includes the child's PCP or a behavioral pediatrician, a child psychiatrist, a speech and language pathologist and other ancillary clinical specialists as needed. These can include:
- A child psychologist
 - A neurologist
 - An audiologist
 - An occupational therapist
 - A physical therapist
 - A special education teacher
 - A medical geneticist
- B. A thorough evaluation (including a parent and/or caregiver interview including siblings) should include the following:
1. Pre- and Perinatal history
 2. Past medical history, review of systems
 3. Developmental and behavioral history
 4. Academic history if child is of school age
 5. (note for # 3-4 include review of past and current educational and behavioral interventions)
 6. Family medical and mental health history
 7. Family functioning
 8. Coping resources
 9. Direct observation of the child with focus on social interaction and restrictive, repetitive behaviors
 10. Comprehensive evaluation by a speech-language pathologist that includes vocabulary, actual language use skills, both receptive and expressive, articulation and oral-motor skills.
 11. Evaluation of academic achievement for children six years of age or older
 12. Occupation and physical therapy testing if sensory or motor difficulties are present
 13. Comprehensive medical evaluation that should include:
 - A complete medical history, review of past records and interviews with family and child
 - A thorough physical that includes a careful neurological exam
 - A Wood's lamp examination of the skin for signs of tuberous sclerosis
 - Routine visual screening
 - Measurement of blood lead level if the child exhibits developmental delay and pica, or lives in a high-risk environment



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- Quantitative plasma amino acid testing to detect phenylketonuria
 - Chromosomal microarray genetic testing
 - Additional laboratory and other tests should be conducted based on clinical history, physical examination and family history, including
 - Metabolic testing: work-up for inborn errors in metabolism other than phenylketonuria if clinical and physical findings suggestive of a metabolic disorder are present and/or mental retardation is suspected.
 - Additional genetic testing, specifically high resolution chromosome analysis (karyotype) and DNA analysis for fragile X syndrome in the presence of suspected mental retardation, a family history of fragile X syndrome or family history of mental retardation of unknown etiology
 - Sleep-deprived EEG should be considered only if the child exhibits seizures or is suspected of having subclinical seizures
14. Formal hearing evaluation including frequency-specific brainstem auditory evoked response
15. Evaluation of the child's cognitive and adaptive functioning, including:
- An assessment, including a full mental status examination by a child psychiatrist to check for possible comorbid conditions or to prevent an erroneous diagnosis
 - Intelligence and adaptive skills testing by a child psychologist, as mental retardation frequently accompanies ASD and to establish priorities for interventions
 - Psychological and Neuropsychological testing if there is a question regarding the presence of a psychiatric or neurological condition other than, or in addition to, autism
16. Assessment tools developed that may assist in the assessment of ASDs including:
- Autism Diagnostic Observation Scale – Generic (ADOS-G), “presses” for socio-communicative behaviors often delayed, abnormal or absent in autistic children
 - Diagnostic Interview for Social and Communication Disorders (DISCO) structured interview rated by clinician, for use with children and adults
 - Autism Diagnosis Interview- Revised (ADI-R), structured interview performed with parents or caregiver

III. It is the policy of Health Net of California that the following are **investigational** in screening, diagnosing and treating autism spectrum or pervasive developmental disorders:

1. Allergy testing (especially food allergy for gluten, casein, candida and other molds)
2. Auditory integration training (auditory integration therapy)



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3. Chelation therapy
4. Cognitive rehabilitation
5. Elimination diets (e.g. gluten and/or milk elimination)
6. Erythrocyte glutathione peroxidase studies
7. Event-related brain potentials
8. Facilitated communication
9. Hair analysis for trace elements
10. Holding therapy
11. Hyperbaric oxygen therapy
12. Immune globulin infusion
13. Intestinal permeability studies
14. Magnetoencephalography/magnetic source imaging
15. Music therapy and rhythmic entrainment interventions
16. Neuroimaging studies such as CT, MRI, MRS, PET, SPECT and fMRI, even in the presence of megalencephaly
17. Nutritional supplements (e.g., megavitamins, high-dose pyridoxine and magnesium, dimethylglycine, omega-3 fatty acids)
18. Nutritional testing
19. Pet therapy (e.g., Hippotherapy)
20. Provocative chelation tests for mercury
21. Routine EEG studies
22. Secretin infusion
23. Sensory integration therapy
24. Stool analysis
25. Tests for celiac antibodies
26. Tests for immunologic or neurochemical abnormalities
27. Tests for micronutrients such as vitamin levels
28. Tests for mitochondrial disorders including lactate and pyruvate
29. Tests for thyroid function
30. Tests for urinary peptides
31. Vision therapy

Background

Autism Spectrum Disorder is a developmental disorder that presents in the first few years of life and profoundly interferes with the individual's lifelong functioning. ASD is characterized by impairment in two core areas:

1. Deficits in social interaction and social communication across multiple contexts, such as
 - Deficits in social reciprocity
 - Deficits in nonverbal communicative behaviors used for social interaction
 - Deficits in developing, maintaining and understanding relationships
 - Specify Current Severity:
 - Severity is based on social communication impairments and restricted , repetitive



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patterns of behavior

2. Restricted, repetitive patterns of behaviors, interests or activities that must include at least two of the following:
 - Stereotyped or repetitive motor movements, use of objects, or speech
 - Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior
 - Highly restricted interests, fixated interests that are abnormal in intensity or focus
 - Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment
 - Specify current /Severity:
 - Severity is based on social communication impairments and restricted, repetitive patterns of behavior

The degree of impairment in these areas varies widely from child to child. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life. (Ref. DSM V Criteria)

The 2011 Interagency Autism Coordinating Committee Strategic Plan for Autism Spectrum Disorder Report dated January 18, 2011, reported that ASD affects an estimated 11.3/1000 children in the United States. The risk is 4-5 times higher in males than in females, however females with autism tend to be more severely intellectually disabled. Compared to the prevalence of other childhood conditions, the rates for Intellectual Disability are 9.7/1000, cerebral palsy is 2.8/1000, hearing loss is 1.1/1000 and vision impairment is 0.9/1000.

The prevalence of ASD is increasing, but it is not clear if this represents an actual increase in the condition, or if other variables are making it appear that way. These include variability in diagnostic criteria and practices, the age of the children screened and where the study was done. (Note: The Centers of Disease Control and Prevention gave a new estimate of 15 percent increase in prevalence nationally: 1 in 59 children, from 1 in 68 two years previous. However, prevalence estimates varied widely between monitoring sites depending on access to school records. Ref: Autism Speaks. Prevalence is not yet clear as there have been changes in the diagnostic criteria, making the diagnosis more inclusive.

Etiology

The etiology of ASD is unknown. It is a disorder involving multiple and diverse neural systems, but no single unifying explanation exists. There is strong support for ASD being genetically determined, at least in part. The recurrence risk for ASD in siblings (2-18.7%), and even higher concordance in identical twins, provides some of this support. In addition, ASD is associated with other conditions that are known to be inherited, such as fragile X syndrome and tuberous sclerosis. Other genetically determined conditions, such as untreated phenylketonuria and methylmalonic aciduria are associated with ASD-like behaviors.



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Environmental factors, such as viruses, are being studied. It used to be thought that parental actions caused autism, but this has never been substantiated and in fact parents are nearly always their autistic child's most effective advocates. Another environmental agent that has been discredited is thimerosal, a preservative that was used in many vaccines until its use was discontinued in 1999. The main *Lancet* study that suggested a link between thimerosal and autism was found to be flawed and, as a result, the article has been withdrawn from the journal.

Known risk factors are close spacing of pregnancies, older maternal or paternal age and extreme prematurity (less than 36 weeks gestational age).

Some Developmental Indicators of ASD

The infant does not babble by 12 months; or

The infant does not gesture (e.g. pointing, waving bye-bye) by 12 months; or

The toddler is not speaking single words by 16 months; or

The toddler is not speaking spontaneous two-word phrases by 24 months (not just the immediate and involuntary repetition of words or phrases spoken by others); or

The toddler does not respond to their own name

Loss of any language or social skills at any age

Other possible indicators:

- Poor eye contact
- Not knowing how to play with toys
- Excessively lines up toys or objects
- Is attached to one particular toy or object
- Doesn't smile
- At times, seems to be hearing impaired but at other times not

Symptoms associated with ASD

Individuals with an ASD may display a range of behaviors that can include:

- Hyperactivity
- Short attention span
- Self-injurious behavior
- Impulsivity
- Aggressiveness
- Temper tantrums, especially in young children or in unfamiliar situations

Individuals with an ASD can experience abnormalities in:

- Eating (preference for few foods and peculiar tastes)
- Sleeping (recurrent waking with rocking)
- High pain tolerance
- Oversensitivity to being touched, or to sounds or lights
- Fascination with certain stimuli or objects
- Abnormal reaction to danger (lack of response to real dangers but excessive fear of



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harmless objects)

Most children with an ASD demonstrate impairments in one or more of the three core areas by the age of 18 months. In most cases they seem to be affected from birth, while in others the child appears to develop normally until age one or two and then regresses. However, it is estimated that about half of all cases are not diagnosed until the child is age 4-6, resulting in a delay in an appropriate assessment and implementation of medical treatment and other behavioral strategies.

ASD is often diagnosed when parents become concerned that their child:

- May be deaf (child is unresponsive to speech, parents' voices or is not learning to talk)
- Seeks affection mainly on his or her own terms (fails to cuddle, shows indifference or aversion to affection or physical contact, doesn't respond to smiles)
- Seems bored or uninterested in conversation or play going on in those around him or her or has little sense of other people's boundaries (can be inappropriately intrusive in social situations, as though no one else exists)
- Does not call attention to things he or she finds interesting (may use parent's or another person's hand to obtain a desired object without looking at the person whose hand it is)

Screening for ASD

It has long been the position of specialty groups such as the Academy of Child and Adolescent Psychiatry and the American Pediatric Society as well as the National Institutes of Health and the Centers for Disease Control that all children should be informally screened for ASD at well baby and child examinations, and specifically screened for ASD at 19 and 24 months of age.

In August of 2015, the U.S. Preventive Services Task Force (USPSTF) published its *Draft Recommendation Statement Autism Spectrum Disorders: Screening*, which stated that current evidence is "insufficient to assess the balance of benefits and harms of screening for autism spectrum disorders (ASD) in children for whom no concerns of ASD have been raised by their parents or clinical provider." While there has been a firestorm of criticism from various quarters regarding this draft recommendation, it should be noted that it is only a draft that was distributed for comments and that the final recommendation has not yet been published. It should further be noted that no action has been taken as a result of this draft by any professional societies, nor have any evidence-based practice guidelines been modified as a result.

Making and Communicating the Diagnosis

The diagnosis of ASD results from the careful synthesis of all of the clinical data gathered with DSM-5/ICD-10 diagnostic criteria. Differential diagnosis includes other developmental disorders, primary disorders of language and psychiatric disorders.

Even though the parents have known something was "not quite right" with their child, being informed of the diagnosis is devastating. Often they will find it hard to focus on anything said after that, or be unable to ask questions or comprehend what is being recommended as the next step. It is vital that clinicians understand that what they are saying is likely not being heard in its entirety. Providing written information and the names of the clinicians who can be contacted



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with questions can be of great assistance. It is also useful to suggest that the parents begin to keep a journal in which to write down the many questions they will have in the days and months ahead.

Treatment

There is no cure for ASD, but they are treatable. The younger the child is at the time of diagnosis and implementation of treatment, the better the outcome will be. The outcome is best for children with good language skills and normal to high IQs who do not have comorbidities such as seizures or psychiatric disorders. While only a small percentage of people with ASD will grow up to live and work independently, each child's individual potential should be developed as far as possible. Interventions should be selected based on enhancing the child's existing functional strengths and addressing the learning disability weaknesses.

There is no broad-based consensus on which clinical and academic strategies are most effective, but many interventions have been developed to address the social, language and behavioral/sensory problems that are the core features of ASD. Therefore, clinicians, the school system, other public resources and parents need to work collaboratively in the optimal management of the child's disorder. Because of the many clinicians, teachers and government agencies that will be involved in the treatment of each child, it is best for one clinician to be the point person in coordinating the overall treatment efforts.

Services that medical clinicians may need to provide, in addition to regular well-child care, include:

- Management of seizure disorder by a neurologist
- Interventions to improve verbal and nonverbal communication skills by a speech-language pathologist
- Physical and occupational therapy for co-morbid physical sensory or motor impairments when medically necessary
- Alternative and augmentative communication aids (e.g., sign language, flashcards, communication boards, etc.) if demonstrated effective for the individual with an ASD

Services that behavioral health clinicians may need to provide include:

Psychiatric interventions

- Evaluation for comorbid conditions, which are not infrequent in children with ASD
- Medication management for specific target symptoms or comorbid conditions:
 - There is evidence that two atypical antipsychotics, risperidone (Risperdal), aripiprazole (Abilify) as well as the SSRI antidepressant fluoxetine (Prozac) can be effective in managing repetitive and stereotypic behaviors. These can also assist with managing challenging behaviors such as aggression, irritability and self-injury in children with ASD. (Risperdal is approved by the FDA to treat autism-related irritability for children 5 years and older. Aripiprazole is approved by the FDA for the treatment of irritability in children ages 6 to 17 years old with ASD.) However, the atypical agents in particular have significant side effects, including weight



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- gain, metabolic syndrome and extrapyramidal symptoms, which can limit their use.
- Other SSRIs have been used to attempt to manage both anxiety and repetitive behaviors, but there is as yet insufficient evidence to support the effectiveness of these agents for this use.
 - Psychostimulants have been used to manage symptoms of inattention and hyperactivity, however there is as yet insufficient evidence to support the effectiveness of the use of these agents for this purpose in children with ASD who do not have comorbid ADHD. There is also some evidence that children with ASD who respond positively to psychostimulants have more problems with side effects than children who do not have an ASD.
 - Alpha 2 Agonists have been used to help manage some symptoms associated with ASD or comorbid diagnosis such as hyperactivity, irritability, inappropriate speech, stereotypy, inattention, and sleep difficulties.
 - Mood stabilizers have been used to help manage some associated symptoms such as irritability, repetitive behavior, and impairment of social behavior. Results have been inconsistent.
 - Norepinephrine reuptake inhibitors (Atomoxetine HCL) has been helpful in managing associated symptoms such as hyperactivity and inattention. (Ref. #3)
- Inpatient hospitalization if there is an acute onset of aggression towards others or danger to self.

Psychotherapeutic interventions

- Family therapy to help parents and siblings cope with the diagnosis and the child's behaviors
- Brief psychotherapy to teach behavioral modification techniques to parents to assist in managing their child.
- Individual cognitive-behavioral psychotherapy (CBT) for adolescent and young adult individuals with an ASD who are capable of insight and who become anxious and/or depressed when they realize the seriousness of their impairment, or for anger management.
- Applied Behavioral Analysis (ABA) is a specific behavioral intervention that focuses on specific behaviors such as social skills, communication, adaptive learning skills such as fine motor skills, hygiene, grooming, job competence and domestic capabilities. It is often effective in the home, school, workplaces and clinics. (www.psychologytoday.com/us/therapy-types/applied-behavior-analysis)

Alternative/complimentary Medicine

It is not uncommon for families of children with ASD to use alternative or complementary treatments as a part of their own treatment of their child or children, in spite of the fact that these types of approaches have very limited empirical support for their use. The clinician who is treating the child must, therefore, be familiar with these approaches and inquire as to whether or



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not they are being used. Open, non-judgmental, educational discussions need to take place about the cost of these treatments, the evidence for or against them and which treatments may pose a danger for the child. For example, intravenous infusion of secretin, and oral vitamin B6 and magnesium have repeatedly been shown to not work. Randomized, controlled trials to study the gluten-free, casein-free diet, the use of omega-3 fatty acids and administration of oral human immunoglobulin do not support the use of these approaches. Finally, some treatments pose an actual risk to the child, such as the mortality and morbidity that is associated with chelation. Some “natural” compounds have contaminants that can put the child at risk. Finally, all of these approaches consume resources, both financial and personal.

The Public School System

An important potential source of help for children with autism is the public school system. Under Federal Public Law 94-142 (the Individuals with Disabilities Education Acts of 1990 and 1997), each school is supposed to provide handicapped children with a free, appropriate education through the age of 21. The school is supposed to evaluate each child and, with the parents, develop an Individual Education Plan (IEP) for him or her. The evaluation may include:

- Developmental and intelligence testing
- Neuropsychological and/or educational achievement testing
- Adaptive skills testing, which is essential to document the presence of associated mental retardation and to establish priorities for interventions
- Speech, language and communication testing that include vocabulary, actual language use skills, both receptive and expressive, articulation and oral-motor skills.
- Pragmatic skills testing to determine the child’s level of communication skills relative to social contexts
- Occupation and physical therapy testing if sensory hyper- or hypo-sensitivities are present

Once the evaluation is completed and the information is combined with information from other sources, the IEP is developed. The plan should document specific and/or measurable goals and how these will be achieved. The plan will determine the educational setting that is most appropriate for the child. Goals for each child are both academic and behavioral/social and the educational setting needs to address both. The IEP is revisited on a regular basis over time to allow for changes to be made in response to the child’s progress or the presentation of new difficulties.

Two structured educational models provided by some schools have been found to have efficacy for children with ASD. These are the Early Denver Start Model and the Treatment and Education of Autism and related communication Handicapped Children (TEACCH) program.

Unfortunately, the level of services the public school system is able to provide varies considerably not only from state to state, from school district to school district within each state, mainly due to funding issues. It is important, therefore, that medical and behavioral health clinicians who treat children with ASD are familiar with the services offered by the school system in their local areas.



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Parents

Parent training and education should be an ongoing part of any intervention program. Parents need to learn about positive reinforcement and how to use behavioral strategies. The same behavioral strategy needs to be used in the home, school or pre-school setting, so parents, teachers and caregivers need to work together to ensure consistency. All children's needs change as they grow, so the behavioral strategy will need to be modified over time to meet new needs.

The parents, caregivers and siblings of an autistic child need support and respite. There are a number of organizations, such as the Autism Society of America, that provide ongoing support and education.

The federal government, through Part C of the Individuals with Disabilities Education Act, mandates an Early Intervention (EI) program to find and treat children with special needs who are under 3 years old. The programs vary from state to state but the package of services available is consistent, requiring access and programming in a natural setting such as the home or another place familiar to the child. All services are free of charge, independent of the family's income.

To locate the EI in each state go to: <http://www.parentcenterhub.org/repository/partc/> then select a state and click on State Agencies.

Genetic counseling should be strongly considered for parents whose child's autism is associated with a defined etiology such as fragile X syndrome.

Other Community Resources

Federal, state and local governments often offer additional and even lifelong services to people with ASD. The best sources of information about these are the Early Intervention program staff, the local school district or local subspecialty clinic that conducts diagnostic evaluations for autistic children.

State mandates related to ASD are available at:

<http://www.asha.org/Advocacy/state/States-specific-Autism-Mandates/>

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2015, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to



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DD-9 codes, DSM-IV-TR/DSM-V Codes and Description related to this policy

CPT® Codes	Description
99080	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form
90801	Psychiatric diagnostic interview examination
90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services
90805	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services;
90807	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services
90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services
90809	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services
90810	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;
90811	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services
90812	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;
90813	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services
90814	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;
90815	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or



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	outpatient facility, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)
90853	Group Psychotherapy (Other than of a multiple-family group)
90857	Interactive group psychotherapy
90862	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
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.
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
96120	Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report
96152	Health and behavior intervention, each 15 minutes, face-to-face; individual
H0031	Mental health assessment, by non-physician
H0032	Mental health service plan development by non-physician
H2019	Therapeutic behavioral services, per 15 minutes
0360T 0362T	Observational behavioral follow-up assessment
0373T	Exposure adaptive behavioral treatment

HCPCS Codes	Description

ICD-10-CM Code	Description
F84	Pervasive Developmental Disorders*
F84.0	Autistic disorder (Autism Spectrum Disorder)
F84.2	Rett's syndrome*
F84.3	Other childhood disintegrative disorder*
F84.5	Asperger's syndrome*
F84.8	Other pervasive developmental disorders*
F84.9	Pervasive developmental disorder, unspecified*

Reviews, Revisions, and Approvals	Approval Date
MHN Clinical Practice Committee Approval	June 2006
HN Medical Advisory Council initial approval	July 2006



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Medical Advisory Council review of external specialty expert comment – no change in policy	September 2006
Updated – added Hyperbaric oxygen therapy (HBOT) as not medically necessary	December 2006
Code update	March 2007
Update – no revisions – further rationale and references added	November 2007
Update – no revisions	January 2008
HN Medical Advisory Committee	May 2008
MHN Clinical Practice Committee Review	October 2008
Updated by MHN and approved by the Medical Advisory Council Removed LOVASS et al from investigational list to educational interventions	December 2008
Update. No revisions. Codes reviewed.	February 2010
MHN, no revisions	March 2011
Update, revisions made related to state mandates for ABA coverage, MHN and HN Medical Advisory Board	November 2011
Added section on early intensive behavioral intervention to the Scientific Rationale and added specific CPT codes and a link to state mandates	January 2012
MHN, No revisions	December 2012
Update. No clinical revisions.	January 2013
MHN, nomenclature revision only to reflect publication of DSM-V	December 2013
Update, no clinical revisions MHN update, clinical revisions HN MAC update, clinical revisions, Codes updated	January 2014 September 2014 November 2014
MHN update, no clinical revisions HN MAC, update, no clinical revisions	September 2015 November 2015
Reviewed by MHN medical director and HN Medical Advisory Council No changes	November 2016
Added codes: 0360T, 0362T, 0373T, Removed S5108	March 2017
New template, removed references to ABA and added reference to separate policy on Applied Behavioral Analysis policy	May 2017
MHN annual review: No revisions	November 2017
Health Net Medical Advisory Council	November 2018

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.



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This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.



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