Subject: Autism Spectrum Disorders: Diagnosis and Treatment

Medical Policy #: 1.4 **Original Effective Date:** 07/22/2009

Status: Reviewed **Last Review Date:** 09-28-2022

Disclaimer

Refer to the member's specific benefit plan and Schedule of Benefits to determine coverage. This may not be a benefit on all plans or the plan may have broader or more limited benefits than those listed in this Medical Policy.

Description

Autism spectrum disorder is a DSM-5 disorder encompassing the previous DSM-IV autistic disorder (autism), Asperger's disorder, childhood disintegrative disorder, Rett's disorder, and pervasive developmental disorder not otherwise specified. New Mexico 13-7.16 "autism spectrum disorder" means a condition that meets the diagnostic criteria for the pervasive developmental disorders published in the Diagnostic and Statistical Manual of Mental Disorders, current edition, published by the American psychiatric association, including autistic disorder; Asperger's disorder; pervasive development disorder not otherwise specified; Rett's disorder; and childhood disintegrative disorder

Significant symptoms associated with ASD include, but are not limited to the following:

- Communication deficits
- Social behavior deficits
- Restricted, repetitive and stereotyped patterns of behavior, interests and activities

Coverage Determination

Prior Authorization is required, please access the following:

- **For Medicaid Care:**
  - nmMedicaidcare@magellanhealth.com
  - https://www.phs.org/providers/resources/Pages/portals.aspx for access to the PHP provider portal and this is preferred over email. Note: this is for BH Medicaid Care only. BH Medicaid Care Fax # 505-843-3019
- **For Commercial:**
  - www.magellanhealth.com/provider
  - Commercial Fax# 1-888-656-4219

Autism spectrum disorders (ASD) are covered for the following services:

1. Well-baby or well-child screening for diagnosing the presence of ASD;
   and
2. Treatment of ASD through
   - Speech therapy
   - Occupational therapy
   - Physical therapy
   - Applied behavioral analysis (Prior Authorization/Benefit Certification required)
3. Coverage for treatment of autism spectrum disorder with those therapies mentioned above shall not be denied to an enrollee on the basis of the enrollee's age.
4. Services for ASD are covered when the following criteria are met:
   - Diagnostic eligibility must be established, using the diagnostic criteria for autism spectrum disorder published in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition, also known as DSM-5, published by the American Psychiatric Association.

Limitation

State of New Mexico mandates that all state regulated plans provide coverage for Autism Spectrum Disorder (ASD). According to the Affordable Care Act (ACA) and Autism and Related Conditions, "health insurance plans are no longer allowed to deny, limit, exclude or charge more for coverage to anyone based on a preexisting condition, including autism and related conditions". Health plans cannot put a lifetime dollar limit on most benefits and the law does away with annual dollar limits a health plan can place on most benefits.

This benefit may be limited to exclude coverage for services received under federal Individuals with Disabilities Education Improvement Act (IDEA) of 2004 and related state laws to school boards for providing specialized education and related services to children age 3 to 22 who have ASD.
Care Coordination oversight is required. Services, which may include speech therapy, physical therapy, occupational therapy and ABA therapies, must be certified as medically necessary. Services provided by family or household members will not be reimbursed.

Documentation
For Commercial members documentation from the ordering physician must include the following

- Diagnosis, including date of initial diagnosis by the appropriate specialist, and if required, annual evaluation to reconfirm the diagnosis
- Proposed treatment by types (i.e., ST, PT, OT or ABA)
- Frequency and duration of treatment
- Anticipated outcome stated as goals
- Frequency treatment plan will be updated
- Signature of treating physician

Applied Behavioral Analysis (ABA)
ABA services provide teaching, training and coaching activities designed to assist the recipient with autism disorders in acquiring, enhancing or maintaining social, behavioral and living skills necessary to function successfully within his home and community setting. ABA services must be supervised by a certified ABA provider (see definitions below).

1. **For Commercial members:**

   Prior Authorization is required for codes (H2019, H0031, H0032, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T and 0373T).

   The following documentation for ABA services should be completed by the certified ABA supervisor:

   An initial assessment to identify problem behaviors and analyze actions likely to trigger or support the problem behavior. This assessment should include clinical issues, legal and/or ethical issues, and family perspective.

   A behavioral treatment plan detailing goals of therapy and the targeted skills and behavior that will be addressed. The treatment plan should include the specific evidence-based ABA techniques to be used to increase the member's adaptive behaviors and modify maladaptive or inappropriate behaviors. In addition, the treatment plan should describe the parental/caregiver training to support and maintain the adaptive skills development for the member.

   Progress reports will address the outcomes of ABA therapy, and if appropriate, modify treatment goals and ABA techniques of intervention. Progress reports should summarize the member's progress and challenges in meeting the goals, as well as the parental/caregiver participation. ABA treatment plan and progress reports modifying the treatment goals should be approved by the ordering physician**.**

2. **For Medicaid Care members:**

   Refer to NMAC (8.321.2.12 NMAC) ABA fee schedule 2019, and State of New Mexico Medical Assistance Program Manual Supplement Number 22-02 for guidance.

   Prior Authorization is required for 0373T and 97153

   ABA services are provided to an eligible recipient who has a well-documented medical diagnosis of autism spectrum disorder (ASD), and for eligible recipients who have well-documented risk for the development of ASD. ABA services are provided to an eligible recipient as part of a three-stage comprehensive approach consisting of evaluation, assessment, and treatment which stipulates that ABA services be provided in coordination with other medically necessary services (e.g., family infant toddler program (FIT) services, occupational therapy, speech language therapy, medication management, developmentally disabled waiver services, etc.). ABA services are part of the early periodic screening, diagnosis and treatment (EPSDT) program (CFR 42 section 441.57). There is no age requirement to receive ABA services and ABA is a covered benefit for Medicaid-enrolled adults.

   A. **Coverage Criteria:**
      1. Confirmation of the presence or risk of ASD must occur through an approved autism evaluation provider (AEP) through a comprehensive diagnostic evaluation (CDE) used to determine the presence of and a diagnosis of ASD. A targeted evaluation is used when the eligible recipient who has a full diagnosis of ASD presents with behaviors that are changed from the last CDE. An ASD risk evaluation is used when an eligible recipient meets the at-risk criteria found in Subsection C of 8.321.2.12 NMAC (see below).
      2. An integrated service plan (ISP) must be developed by the AEP together with a referral to an approved ABA provider (AP) agency (stage one).
      3. The AP agency completes a behavior or functional analytic assessment. The assessment results determine if a focused or comprehensive model is selected and a treatment plan is completed (stage two).
      4. ABA stage two and three services are then rendered by a behavior analyst certification board (BACB) approved behavior analyst (BA), a board certified assistant behavior analyst (BCaBA) or a behavior

technician (BT), in accordance with the treatment plan (stage three). A BCaBA is referred to 8.321.2 NMAC as a behavior analyst assistant (BAA).

B. **Eligible providers**: ABA services are rendered by a number of providers and practitioners: an AEP; a behavior analyst (BA) and a behavior technician (BT) through an ABA provider (AP); and an ABA specialty care provider. Each ABA provider and practitioner has corresponding enrollment requirements and renders unique services according to his or her provider type and specialty. All providers must successfully complete a criminal background registry check. See Subsections A and B of 8.321.2.9 NMAC for MAD general provider requirements. For complete description of eligible providers requirements see 8.321.2.12.B. (1) thru (6).

C. **Identified population:** The admission criteria are separated into two types: at-risk for ASD and diagnosed with ASD.

1. **At-risk for ASD**: an eligible recipient may be considered 'at-risk' for ASD and therefore eligible for time-limited ABA services, if he or she does not meet full criteria for ASD per the latest version of the diagnostic statistical manual (DSM) or international classification of diseases (ICD). To be qualified for the ABA criteria of at-risk, the eligible recipient must meet all the following requirements:
    a) is between 12 and 36 months of age;
    b) presents with developmental differences and delays as measured by standardized assessments;
    c) demonstrates some characteristics of the disorder (e.g., impairment in social communication and early indicators for the development of restricted and repetitive behavior); and
    d) presents with at least one genetic risk factor (e.g., genetic risk due to having an older sibling with a well-documented ASD diagnosis; eligible recipient has a diagnosis of Fragile X syndrome).
2. **Diagnosed with ASD**: an eligible recipient who has a documented medical diagnosis of ASD according to the latest version of the DSM or the ICD is eligible for ABA services if he or she presents with a CDE or targeted evaluation.

D. **Covered services:**

1. **Stage one**: An eligible recipient is referred to an AEP after screening positive for ASD. The AEP conducts a diagnostic evaluation (CDE or targeted evaluation), develops the ISP, and recommends ABA stage 2 services. For an eligible recipient who has an existing ASD diagnosis, diagnostic re-evaluation is not necessary, but the development of an ISP and the determination of the medical necessity for ABA services are required.
2. **Stage two BA**: For all eligible recipients, stage two services include a behavior or functional analytic assessment, ABA service model determination, and treatment plan development. The family, eligible recipient (as appropriate for age and developmental level), and the AP's supervising BA work collaboratively to make a final determination regarding the clinically appropriate ABA service model, with consultative input from the AEP as needed. A behavior or functional analytic assessment addressing needs associated with both skill acquisition and behavior reduction is conducted, and an individualized ABA treatment plan, as appropriate for the ABA service model, is developed by the supervising BA. The BA is responsible for completing all of the following services: (a) the recipient's assessment; (b) selection and measurement of goals; and (c) treatment plan formulation and documentation.
3. **Stage three - treatment:** Most ABA stage three services require prior authorization and may vary in terms of intensity, frequency and duration, the complexity and range of treatment goals, and the extent of direct treatment provided.
4. **Stage three - clinical management and case supervision:** All stage three services require clinical management. If a BAA or a BT is implementing the treatment plan, the BAA or BT requires frequent, ongoing case supervision from his or her BA or supervising BAA. The BH policy and billing manual provides a detailed description of the requirements for rendering clinical management and case supervision.
5. **Stage three - ABA specialty care services:** Specialty care services require prior authorization. In cases where the needs of the eligible recipient exceed the expertise of the AP and the logistical or practical ability of the AP to fully support the eligible recipient MAD covers the eligible recipient for a referral to a MAD enrolled ABA specialty care practitioner (SCP).
6. If the eligible recipient is in a residential facility or institutional setting that either specializes in or has as part of its treatment modalities MAD ABA services, and the residential facility is not an AP for ABA stage two and three services, and the eligible recipient has a MAD recognized CDE or targeted evaluation which recommends ABA stage two services, the residential facility is responsible to locate a MAD enrolled ABA stage two and three AP and develop an agreement allowing the AP to render stage two and three services at the residential facility. Reimbursement for ABA stage two and three services is made to the MAD enrolled AP, not the residential facility.
7. For an eligible recipient who meets the criteria for ABA services and who is in a treatment foster care (TFC) placement, he or she is not considered to be in a residential facility and may receive ABA services outside of the TFC agency. An eligible recipient who meets the criteria for ABA services who is in a residential treatment center, accredited residential treatment center, or a group home may receive ABA services to the extent that the residential provider is able to provide the services.

8. See the BH policy and billing manual for specific instructions concerning stages one through three services.

E. **Prior authorization - general information stage three services:** (1) Prior authorization to continue ABA stage three services must be secured every six months. At each six-month authorization point, a UR contractor will assess, with input from the family and AP's BA, whether or not changes are needed in the eligible recipient's ISP or treatment plan. Additionally, the family or AP may request ISP modifications prior to the UR contractor's six-month authorization point if immediate changes are warranted to preserve the health and wellbeing of the eligible recipient. For complete description of prior authorization information see 8.321.2.12.E. (1) thru (6).

F. **Non-covered services:**

1. The eligible recipient's comprehensive or targeted diagnostic evaluation or the ISP and treatment plan updates recommend placement in a higher, more intensive, or more restrictive level of care (LOC) and no longer recommends ABA services.
2. Activities that are not designed to accomplish the objectives delineated in covered services and that are not included in the ABA treatment plan.
3. Activities that are not based on the principles and application of applied behavior analysis.
4. Activities that take place in school settings and have the potential to supplant educational services.
5. Activities that are better described as another therapeutic service (e.g., speech language therapy, occupational therapy, physical therapy, counseling, etc.), even if the practitioner has expertise in the provision of ABA.
6. Activities which are better characterized as staff training certification or licensure or certification supervision requirements, rather than ABA case supervision.

Speech therapy, physical therapy and occupational therapy:

Prior Authorization is not required; however, all claims are subject to retrospective review, and should be billed with autism as the primary diagnosis. The following documentation may be required to demonstrate medical necessity:

- Initial assessment to identify goals and objectives of therapy
- Treatment plan detailing goals of therapy and techniques to be used
- Progress reports addressing the outcomes of therapy, and when appropriate, modification of treatment goals.

Coding

The coding listed in this medical policy is for reference only. Covered and non-covered codes are within this list.

For Applied Behavior Analysis (ABA) proposed fee schedule for Medicaid fee for service effective Oct 01, 2019

Current Procedural Terminology (CPT) Codes

CPT	Code status. For Medicaid, see above ABA link on how to use these codes and their modifiers.
T1026	Intensive, extended multidisciplinary services provided in a clinic setting to children with complex medical, physical, medical and psychosocial impairments, per hour
0362T	Intensive, extended multidisciplinary services provided in a clinic setting to children with complex medical, physical, medical and psychosocial impairments, per hour
0373T	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.
97151	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan
97152	Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified

	health care professional, face-to-face with the patient, each 15 minutes
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional, face-to-face with guardian(s)/caregiver(s), each 15 minutes
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional, face-to-face with multiple sets of guardians/caregivers, each 15 minutes
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes
H2019	Therapeutic Behavioral Services
H2019- TT	(use of modifier TT), More than one patient in same setting
H0031	Initial Intake evaluation and treatment planning
H0032	Supervision of para-professional in home or office to establish treatment plan

ICD-10 Diagnosis Codes

ICD10 Codes	Covered Diagnosis Description
F84.0	Autistic Disorder. Includes Autism spectrum disorder, Infantile autism, Infantile psychosis, Kanner's syndrome.
F84.2	Rett's syndrome
F84.3	Other childhood disintegrative disorder
F84.5	Asperger's syndrome
F84.8	Other pervasive developmental disorder
F84.9	Pervasive developmental disorder, unspecified (Atypical autism)

Reviewed by / Approval Signatures

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Date Approved: 09-28-2022
Reviewed by:

1. Gray Clarke MD, Senior Medical Director, PHP Government Programs
2. Paula Hensley MD, Psychiatry
3. Anjali Yeolekar-Dasari MD, Medical Director, Medicaid Behavioral Health

References

1. NM Statutes, Rules, and Const. 2017 NMSA (Unannotated) CHAPTER 13 Public Purchases and Property ARTICLE 7 Health Care Purchasing 13-7-16. Coverage for autism spectrum disorder diagnosis and treatment; permissible limitations. (2013). [Cited 07/27/2022]
2. NM Statues, Autism Spectrum Disorder Coverage, 2019 Regular Session – HB 322, SGND by Gov (Apr.2), Ch. 119. Final version 04/02/2019. [Cited 07/27/2022]
3. NMAC# 8.321.2, Specialized Behavioral Health Provider Enrollment and Reimbursement, Effective date: EFF: 8/10/2021. (see 8.321.2.10 for Applied Behavior Analysis). [Cited 07/27/2022]
4. New Mexico Medicaid, Fee for Service, Proposed Fee Schedules or Rates, Applied Behavior Analysis (ABA) Fee Schedule, Updated: Effective October 01, 2019. [Cited 07/27/2022]
5. U.S. Department of Health & Human Services, The Affordable Care Act and Autism and Related Conditions, Content

last reviewed April 9, 2015. Web link can be found https://www.hhs.gov/programs/topic-sites/autism/aca-and-autism/index.html [Cited 07/27/2022]
6. State of New Mexico Medical Assistance Program Manual, Supplement, Applied Behavioral Analysis Guidance, Number 22-02, Date January 27, 2022. [Cited 08/03/2022]

Publication History

03-22-17 Annual Review. Accessed NMAC 8.321.2.10. (unchanged) and Supplement # 16-08 dated 08-23-16. Change in language from "all stages require Prior Auth "to "some stages require Prior Auth".

07-31-19 Annual Review: Update criteria with the new information from 2019 HB 322. NMAC 8.321.2.10 remains the same. Update with new fee schedule. Updated NMAC links. MPM reviewed by Gray Clark.

11-18-20 Annual review. Reviewed by PHP Medical Policy Committee on 10-28-2020. Policy reviewed by Dr. Clark. No change to policy since NMAC 8.321.2.10 and NM Stat 13-7-16 (2017), remains the same. Update the ABA fee schedule (Oct 2019). Will resume PA for 0373T, 97153, 97154, 97155, 97156, 97157, and 97158.

09-22-21 Annual review. Policy reviewed by Dr. Clark. The following are changes to policy:

1. Medicaid (NMAC 8.321.2.12) updated the Applied Behavior Analysis (ABA) as of 08/10/2021, which includes the following:
   A. Coverage criteria
   B. Eligible providers
   C. Identified Type of populations: (At risk for ASD and Diagnosed with ASD)
   D. Covered services: clarifying Stage one thru stage three ABA services
   E. Prior authorization to continue ABA stage three services must be secured every six months
   F. Non-covered services
2. New codes for Commercial LOB added to policy which are still being updated: H2019 –Therapeutic Behavioral Services; H2019 modifier TT – More than one patient in same setting; H0031 – Initial Intake evaluation and treatment planning; H0032 – Supervision of para-professional in home or office to establish treatment plan. Code list without the modifiers: T1026, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T and 0373T.
3. Clarification of PA language: The codes listed in the policy are under review for PA and will be determined at a later date.

09-28-22 Annual review. Reviewed by PHP Medical Policy Committee on 08/12/2022.
For Medicaid: No change to coverage determination. Continue PA requirement for 97153 and 0373T and continue no PA requirement for: T1026, 97151, 97152, 0362T, 97154, 97155, 97156, 97158. Throughout policy removed Centennial with Medicaid.

For Commercial: No change to coverage determination. Continue PA requirement for: H2019, H0031, H0032, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T. Remove PA requirement for code T1026. The fax number has been updated: 888-656-4967 to 4219.

This Medical Policy is intended to represent clinical guidelines describing medical appropriateness and is developed to assist Presbyterian Health Plan and Presbyterian Insurance Company, Inc. (Presbyterian) Health Services staff and Presbyterian medical directors in determination of coverage. The Medical Policy is not a treatment guide and should not be used as such.

For those instances where a member does not meet the criteria described in these guidelines, additional information supporting medical necessity is welcome and may be utilized by the medical director in reviewing the case. Please note that all Presbyterian Medical Policies are available online at: ***Click here for Medical Policies***

Web links:
At any time during your visit to this policy and find the source material web links has been updated, retired or superseded, PHP is not responsible for the continued viability of websites listed in this policy.

When PHP follows a particular guideline such as LCDs, NCDs, MCG, NCCN etc., for the purposes of determining coverage; it is expected providers maintain or have access to appropriate documentation when requested to support coverage. See the References section to view the source materials used to develop this resource document.