Category: Utilization Management

Code: UM 2.0 Attach U Autism Spectrum Disorders in Children: Non-intensive treatment

Subject: Autism Spectrum Disorders in Children: Non-intensive treatment Level of Care Guidelines

Purpose: The purpose of this policy is to describe the criteria used by BHP in medical necessity determinations for Autism Spectrum Disorders in Children: Non-intensive treatment

Policy: BHP Care Management (CM) staff use the following level of care guidelines for Autism Spectrum Disorders in Children: Non-intensive treatment when completing medical necessity determinations.

Please refer to the enrollee's benefit document for specific information. To the extent there is any inconsistency between this policy and the terms of the enrollee's benefit plan or certificate of coverage, the terms of the enrollee's benefit plan document will govern.

Benefits must be available for healthcare services. Healthcare services must be ordered by a physician, physician assistant, nurse practitioner, or behavioral health practitioner. Healthcare services must be medically necessary, applicable conservative treatments must have been tried, and the most cost-effective alternative must be requested for coverage consideration.

GUIDELINES:

Medical Necessity Criteria - must have: I, and one of II-IV, but not V

I. Member is at least age 2 and younger than age 18.

II. Initial treatment – must have all of the following: A – D

A. Confirmed diagnosis from the *DSM* autism spectrum disorder; and

B. Treatment is ordered by a physician**,** physician assistant, nurse practitioner, or licensed mental health provider with *expertise in child development*; and

C. Treatment is supervised by a provider, with *expertise and training in autism* and *child development* and who is a licensed physician, advanced practice nurse, or a mental health professional, and is practicing within the scope of the provider's professional license.

D. Proposed services are based on a comprehensive individualized treatment plan (ITP) that includes documentation of all of the following:

1. Treatment strategies for behavioral change and management of associated symptoms such as aggression or self injury, sleep problems, activity level, and safety; and

2. Persons responsible for each behavioral change strategy, including collaborating applied behavioral therapist, language therapist and allied therapists responsible for specific aspects of behavioral change

and development progression. Strategies involve parents as well as school personnel, when appropriate; and

3. Measurable, functional goals with timeframes that are clearly defined, directly observed, and continually measured; and

4. An expectation of improvement within a clinically reasonable time frame that is due to the treatment rendered, and not what would be expected in the usual growth and development for the individual if no treatment was provided; and

5. Projected timeframes for care with clear criteria for discharge from services; and

6. Plan for transitioning care from the licensed provider when treatment plan goals are met; and

7. Where applicable, previous and current therapy treatment plans provided by other providers for the purpose of coordinating care and avoiding duplication of services.

III. Continued treatment – member continues to meet initial treatment criteria – must also have documentation of all of the following: A-E

A. A progress evaluation is conducted at least every six months by a mental health professional who has *expertise in child development* and training in autism (formal assessment/standardized testing is done at least yearly) with documented evidence of sustained improvement and progress on stated goals demonstrated by improvement in the targeted abnormal findings, symptoms and/or behaviors of concern measured by the same method used for the initial evaluation; and

B. The documented improvement is due to the treatment rendered and not what would be expected in the usual growth and development for the individual if no treatment was provided; and

C. Care continues to be medically necessary due to a continued, demonstrated significant delay in function; and

D. Appropriate modifications to treatment plan are implemented; and

E. Documented plans for tapering and discontinuation of service from the licensed provider(s).

Note: Re-evaluation by the prescribing licensed provider is required every six months. If no or minimal improvement is documented, therapy services are no longer eligible for coverage.

IV. Discharge criteria – any of the following: A-D

A. Treatment is no longer provided by a licensed provider; or

B. Ongoing treatment is primarily *custodial* or *maintenance* in nature and/or does not require the services of a licensed provider; or

C. There is insufficient progress being made to justify further treatment; or

D. Member has met the treatment plan goals.

V. Exclusions – any of the following: A-F

A. Refer to member's benefit plan for specific exclusions.

B. Services provided by non-licensed providers.

C. Education of non-licensed providers, family and/or school personnel in behavioral change strategies.

D. Treatment services as per the Investigative List

1. Auditory Integration Therapy
2. Chelation therapy
3. Cognitive rehabilitation
4. Elimination diets
5. Facilitated communication
6. Holding therapy
7. Hyperbaric Oxygen Therapy
8. Immune globulin infusion
9. Metallothioneim protein treatment
10. Nutritional supplements such as megavitamins, high-dose pyridoxine and magnesium

F. Equine/hippotherapy is considered a plan exclusion under Recreational therapy

DEFINITIONS:

Autism Spectrum Disorder: A range of complex neurodevelopmental disorders, characterized by persistent deficits in social communication and interaction across multiple contexts, restricted repetitive patterns of behavior, interests, or activities, symptoms that are present in the early developmental period, that cause clinically significant impairment in social, occupational, or other important areas of functioning, and are not better explained by intellectual disability or global developmental delay. Such disorders are determined by criteria set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Child Development Expertise: Evidence includes, but limited to, board certification/board eligible in developmental and behavioral pediatrics, fellowship/clinical experience, undergraduate focus in neurobiology or behavior, research involvement, professional/specialty society appointment/membership, and relevant published literature.

Custodial Care: Services to assist in activities of daily living and personal care that do not seek to cure or do not need to be provided or directed by a skilled medical professional, such as assistance in walking, bathing and feeding.

DSM: The most current edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Health Disorders**.**

Habilitative Therapy: Therapy provided to develop initial functional levels of movement, strength, daily activity or speech.

Homebound: A member is considered homebound if they are unable to leave home without a considerable and taxing effort due to a medical condition. A person may leave home for episodic medical treatment or short, infrequent absences for non-medical reasons, to attend a funeral, religious service, or graduation; an occasional trip to the barber, a walk around the block; or other infrequent or unique event (eg, a family reunion or other such occurrence.) A member's inability to drive or lack of transportation does not qualify the member for homebound status.

Maintenance Care: Care that is not *habilitative* or *rehabilitative* therapy and there is a lack of documented significant progress in functional status over a reasonable period of time; performed to maintain clinical status without the ability to expect further clinical improvement, ie, two weeks or more between a therapy session.

Rehabilitative Therapy: Therapy provided to restore functional levels of movement, strength, daily activity or speech after a sickness or injury.

Training in Autism: Evidence includes, but not limited to, fellowship/clinical experience, educational background focusing on Autism Spectrum Disorders, research involvement, professional/specialty society appointment/membership, and relevant published literature.

BACKGROUND:

This criteria document is based on expert professional practice guidelines and/or reliable evidence.
Treatment of autism spectrum disorders requires multidisciplinary management. Optimal treatment and reimbursement is available through a programmatic approach.
Home based services are eligible for coverage only if the member is homebound and not an excluded benefit.

REFERENCES:

1. NIH National Institute of Neurological Disorders and Stroke (NINDS); NINDS Asperger Syndrome Information Page, Last Updated June 15, 2011, Accessed September 13, 2011. NINDS Autism Information Page, Last Updated June 15, 2011, Accessed September 13, 2011. Autism Fact Sheet, NINDS, Publication date September 2009 NIH Publication No. 09-1877, Accessed September 13, 2011. NINDS Pervasive Developmental Disorders Information Page, Last Updated June 15, 2011, Accessed September 13, 2011. NINDS Rett Syndrome Information Page, Last Updated June 15, 2011. Accessed September 13, 2011.

2. National Institute of Mental Health (NIMH). A Parent's Guide to Autism Spectrum Disorder. 2011. Retrieved from http://www.nimh.nih.gov/health/publications/a-parents-guide-to-autism-spectrum-disorder/parent-guide-to-autism.pdf

3. American Academy of Pediatrics. Sensory integration therapies for children with developmental and behavioral disorders. *Pediatrics* 2012;129;1186; doi: 10.1542/peds.2012-0876

4. Myers SM, Plauche Johnson C. Management of children with autism spectrum disorders. *Pediatrics* 2007; 120; 1162. doi: 10.1542/peds.2007-2362.

5. Weissman L, Bridgemohan C. Autism spectrum disorder in children and adolescents: Behavioral and educational interventions. In: *UpToDate*, Torchia (Ed), UpToDate, Waltham, MA. 2013

6. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders Fifth Edition. 2013.

7. Agency for Healthcare Research and Quality (AHRQ). Therapies for Children with Autism Spectrum Disorder: Behavioral Interventions Update. Comparative Effectiveness Review Number 137.

8. Minnesota Statute 43A.23

9. Minnesota Statute 62A.3094

Internal References: Gordon Larson MS LP

Source: PreferredOne, BHP

Date Effective: **05/04/2016**

Date Revised:

Date Evaluated by Clinical Team: **May 2016, December 2016, December 2017**

Revision Tracking

Date Revised	**Revision Type** List all applicable: - Minor changes (Use this when changes are related to staff titles, names of reports or systems, etc). - Change in process/procedure - Change in requirements - New attachments or forms added - Updated documentation to clarify policy - Other	**Details of Revision Made**