

Autism Services Payment Policy

Policy

The Plan covers the diagnosis and medically necessary treatment of autism spectrum disorders. Coverage is provided consistent with Chapter 207 of the Acts of 2010 - An Act Relative to Insurance Coverage for Autism (ARICA) in the state of Massachusetts.

This policy applies to Commercial and MassHealth plans only.

Definitions

Autism spectrum disorders (ASDs) are any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental disorders, including autistic disorder, Asperger's syndrome, and Pervasive Developmental Disorders Not Otherwise Specified (PDD-NOS). There are also two rare and very severe disorders, known as Rett syndrome and Childhood Disintegrative Disorder.

Treatment for ASDs is defined to include habilitative or rehabilitative care, but not limited to, Applied Behavioral Analysis (ABA) therapy, pharmacy, psychiatric, psychological, and therapeutic care (including outpatient physical, occupational, and speech therapies).

ABA therapy is generally only used to treat young children with autistic disorder. ABA therapy is defined as the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Reimbursement

Treatment, benefits, and authorization requirements:

The Plan will coordinate care and review coverage requests for all treatments and therapies for ASDs (including ABA therapy) individually, based on medical necessity. The treatment and benefits for eligible Plan members have no annual or lifetime dollar or unit of service limitations; however, a plan authorization is required for all services related to ASDs.

For Plan-contracted physical therapy (PT), occupational therapy (OT), and speech therapy (ST) providers:

The PT/OT benefit mandated by ARICA is separate from the standard *medical* PT/OT benefit that the Plan covers.

- *Medical*: The Plan will process claims with a medical (non-ASD) primary diagnosis in accordance with the member's medical benefit, typically 60 visits per benefit year with no prior authorization required.
- *ARICA*: The Plan will cover unlimited therapy visits, provided medical necessity is met, a plan authorization is granted prior to the services being rendered, and the primary diagnosis is one of the ASD diagnoses outlined below.

Referral/notification/prior authorization requirements

A plan authorization is required for all services related to ASDs.

Billing/coding guidelines

Applicable ASD primary diagnosis codes:

ICD-10 Diagnosis Code	Description
F84.0	Autistic 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

Claims are to be submitted to the Plan's Claims department, with the exception of ABA therapy claims, which should be sent directly to Beacon Health Strategies.

Place of service

This policy applies to services rendered in all settings.

Policy history

Origination date:	January 1, 2012
Previous revision date(s):	3/1/2014 - Updated list of ASD primary diagnosis codes to include ICD-10 codes. 03/01/2015 - Moved to Fallon Health template and updated codes. 01/01/2016 - Moved to new Plan template and updated reimbursement section to reflect removal of copay. 05/01/2016 - Annual review.
Connection date & details:	March 2017 – Annual review. April 2018 – Annual review, no updates. October 2018 – Updated referral section. October 2019 – Annual review, no updates.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.