MEDICAL POLICY

POLICY TITLE	MEDICAL TREATMENTS OF AUTISM SPECTRUM DISORDER
POLICY NUMBER	MP 2.304

CLINICAL BENEFIT	☒ MINIMIZE SAFETY RISK OR CONCERN. ☐ MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS. ☒ ASSURE APPROPRIATE LEVEL OF CARE. ☐ ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS. ☒ ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET. ☐ ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.
Effective date:	**8/1/2026**

POLICY

Diagnostic Testing and Assessment

Services may be considered **medically necessary** when performed as part of a comprehensive, multidisciplinary diagnostic evaluation for Autism Spectrum Disorder (ASD) when clinically indicated.

Comprehensive Diagnostic Evaluation (CDE) may include:

- Clinical assessment by a qualified professional (e.g., developmental pediatrician, child psychologist, pediatric neurologist)
- Use of validated diagnostic instruments (e.g., ADOS-2, ADI-R)
- Developmental and behavioral history with direct observation
- Speech-language evaluation
- Audiological assessment to rule out hearing deficits
- Neuropsychological testing when clinically indicated

Other Evaluations and Interventions

Sensory integration therapy may be considered **medically necessary** when incorporated into a licensed occupational therapy plan addressing documented functional impairments.

Investigational Services

The following are considered **investigational** for the assessment or treatment of ASD due to insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with the procedure:

- Secretin infusion (in the absence of documented pancreatic disorders)
- Sensory-friendly, weighted, or compression clothing/vests
- Intravenous chelation therapy (in the absence of heavy metal toxicity)
- Auditory integration training (AIT)
- Standalone sensory integration therapy
- Hyperbaric oxygen therapy
- Stem cell therapy

- Allergy or nutritional testing (in the absence of signs or symptoms of a specific underlying condition)
- Specialized diets (e.g., gluten-free/casein-free) when used solely to treat ASD without a diagnosed medical condition

Services Covered Under Other Medical Policies

Coverage for the following services is determined under their respective policies:

- Speech therapy
- Neuropsychological testing
- Genetic testing
- Biofeedback
- Vision therapy
- Evoked potential studies

Policy Guidelines

This policy does not address molecular or genetic testing for the diagnosis and assessment of ASD. These services are managed by the vendor Evicore.

Secretin Infusion

Secretin is a gastrointestinal hormone that stimulates pancreatic secretion. Its use in ASD was based on a hypothesized gut-brain relationship. However, a 2012 systematic review of 16 randomized controlled trials (re-validated by subsequent Cochrane reviews through 2023) found no evidence that secretin improves core features of autism. The use of sensory friendly, weighted or compression clothing has not been thoroughly studied for the treatment of ASD.

Sensory and Compression Clothing

The use of weighted, compression, or sensory-friendly clothing has not been supported by high-quality clinical evidence demonstrating therapeutic benefit for core ASD symptoms.

Cross-references:
MP 2.001 Allergy Testing and Immunotherapy
MP 2.401 Biofeedback for Miscellaneous Indications
MP 4.005 Intravenous Chelation Therapy
MP 4.007 Vision Therapy
MP 4.027 Neuropsychological Testing for Medical Purposes
MP 4.029 Evoked Potential Studies
MP 8.002 Speech Therapy (Outpatient)
MP 8.011 Sensory Integration and Auditory Integration Therapy

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PRODUCT VARIATIONS

This policy is only applicable to certain programs and products administered by Capital Blue Cross and subject to benefit variations. Please see additional information below.

For fully-insured group policies, the Children's Health Insurance Program ("CHIP") policies, and self-funded groups that have opted to be subject to Act 62, the requirements of this policy are applied to the extent permitted by Act 62.

FEP PPO - Refer to FEP medical policy manual. The FEP medical policy manual can be found at: fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies.

The FEP program dictates that all drugs, devices or biological products approved by the U.S. Food and Drug Administration (FDA) may not be considered investigational. Therefore, FDA-approved drugs, devices or biological products may be assessed on the basis of medical necessity. Pennsylvania Act 62 of 2008 does not apply.

DESCRIPTION/BACKGROUND

Autism Spectrum Disorder (ASD) is a neurodevelopmental condition characterized by persistent deficits in social communication and social interaction across multiple contexts (e.g., difficulty with social as well as restricted, repetitive patterns of behavior, interests, or activities.

ASD presents with a wide range of severity and functional impact. Diagnosis is based on clinical evaluation using standardized criteria and validated tools.

Therapeutic Approach

Management of ASD typically involves medical and developmental interventions tailored to individual needs. Not all therapies have demonstrated effectiveness in improving core symptoms, and medical necessity must be based on evidence, functional impact, and clinical benefit.

DEFINITIONS

ASPERGER'S SYNDROME: a condition in which the essential features are less severe with sustained impairment in social interaction and the development of restricted, repetitive patterns of behavior, interests and activities. In contrast to autistic disorder, there are no clinically significant delays or deviance in language acquisition, although more subtle aspects of social communication may be affected. In addition, during the first 3 years of life, there are no clinically significant delays in cognitive development as manifested by expressing normal curiosity about the environment or in the acquisition of age-appropriate learning skills and adaptive behaviors (other than in social interactions).

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AUTISTIC DISORDER: a condition characterized by the presence of markedly abnormal or impaired development in social interaction and communication and a markedly restricted repertoire of activity and interests. The onset usually occurs within the first three years of life.

DISCLAIMER

Capital Blue Cross' medical policies are used to determine coverage for specific medical technologies, procedures, equipment, and services. These medical policies do not constitute medical advice and are subject to change as permitted by law or applicable clinical evidence from independent treatment guidelines. Treating providers are solely responsible for medical advice and treatment of members. These policies are not a guarantee of coverage or payment. Payment of claims is subject to a determination regarding the member's benefit program and eligibility on the date of service, and a determination that the services are medically necessary and appropriate. Final processing of a claim is based upon the terms of contract that applies to the members' benefit program, including benefit limitations and exclusions. If a provider or a member has a question concerning this medical policy, please contact Capital Blue Cross' Provider Services or Member Services.

CODING INFORMATION

Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms and conditions of a member's specific health plan. In addition, not all covered services are eligible for separate reimbursement.

Coding list is not all inclusive. Refer to specific Medical Policy for coding, see cross references

Covered when Medically Necessary:

Procedure Codes								
S9152	V5362	V5363	96116	96121	96132	96133	96136	96137
96138	96139	96146	97533					

ICD-10-CM 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

Investigational:

Procedure Codes								
A9999	J2850							

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POLICY HISTORY

MP 2.304	**02/25/2020 Consensus Review.** No changes to policy statements, all coding reviewed.
	12/11/2020 Administrative Update. Removed deleted codes 92585 and 92586, effective 01/01/2021.
	01/19/2021 Consensus Review. No changes to policy statements. References and coding updated. CHIP language under product variations was revised to state Pennsylvania Act 62 of 2008 does apply.
	08/31/2021 Administrative Update. Added new code 0263U**,** effective 10/01/2021.

	11/22/2022 Major Review. ABA now as MN. Second Tier Genetic Testing as MN and added coding. Formatting and clarification changes throughout.
	05/22/2023 Minor Review. ABA and Behavior therapy removed from policy. Removal of interventions that resided on another policy. Reformatting and clarity throughout. Coding updated.
	08/21/2024 Minor Review. Title updated to Medical Treatments of Austism Spectrum Disorder. Removed statements related to behavioral health services. Updated secretin injections and weighted clothing to investigational. Coding and references reviewed and updated.
	12/11/2024 Administrative Update. Added 96041, removed 96040. Effective 01/01/2025.
	07/02/2025 Consensus Review. Policy statement unchanged. Coding and references reviewed and updated.
	02/23/2026 Minor Review. Removed statements and procedure codes that are going to be managed by the vendor. Updated all policy statements to align with evidence-based guidance and improve clarity. Updated policy guidelines, cross-references, background, and coding table. References updated.
	04/06/2026 Administrative Update. Removed procedure codes that are going to be managed by Evicore. Eff date 07/01/2026.