BlueCross BlueShield of Vermont

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Applied Behavior Analysis (ABA)
Corporate Medical Policy

File Name: Applied Behavior Analysis (ABA) File
Code: 3.01.VT201
Origination: 07/2011 Last
Review: 04/2025 Next
Review: 04/2026
Effective Date: 07/01/2025

Description/Summary

Autism Spectrum Disorder

Autism Spectrum Disorder (ASD) is characterized as persistent deficits in social communication and social interaction across multiple contexts, not accounted for by general developmental delay, as manifested in the following symptoms (examples are illustrated, not exhaustive):

- Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social cues and interactions.
- Deficits in non-verbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and non-verbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and non-verbal communication.
- Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

Severity is based on social communication impairments and restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive):

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal non-verbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route).

3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interest).
4. Hyper- or hypo-reactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

Symptoms must be present in the early developmental period, but they may not become fully manifest until social demands exceed limited capacities, or they may be masked by learned strategies in later life. The symptoms must cause clinically significant impairment in social, occupational, or other important areas of current functioning, and these impairments or disturbances must not be better explained by intellectual disability or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for the patient's general developmental level.

Note: Individuals who have marked deficits in social communication, but whose symptoms don't otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder.

SEVERITY LEVELS FOR AUTISM SPECTRUM DISORDER (ASD) (According to DSM 5)

Severity Level	Social Communication	Restricted, repetitive behaviors
Level 3 – Severe* "Requiring very substantial support"	Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others.	Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.
Level 2 – Moderate* "Requiring substantial support"	Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others.	Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.
Level 1 – Mild* "Requiring support"	Without supports in place, deficits in social communication cause	Inflexibility of behavior causes significant interference with functioning in one or more

	noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful response to social overtures of others. May appear to have decreased interest in social interactions.	contexts. Difficulty switching between activities. Problems of organization and planning hamper independence

*Note: The table above levels “severe”, “moderate”, and “mild” qualifiers are not DSM-V modifiers; they are included here simply to help contextualize the Level 3, Level 2, and Level 1 severity levels, respectively, of ASD.

APPLIED BEHAVIOR ANALYSIS FOR TREATEMENT OF ASD

Applied behavior analysis (ABA) is an empirically developed assessment program for determining environmental variables which mediate behavior, and then developing a behavioral modification program to promote pro-social and encourage safe, non-injurious, behaviors. An ABA treatment plan is developed using some of the following strategies: a functional behavior analysis; observation and measuring antecedents, behaviors, and consequences; criterion referenced assessments (e.g., the verbal behavior of milestones assessment placement program; the activities of functional living skills (i.e., these examples are note intended to be exhaustive). These strategies are used to develop interventions with a focus on environmental changes to promote more adaptive social behaviors. These interventions are administered very consistently, based on the protocols developed. Protocols are then modified based upon accurate quantification of changes in the identified behaviors.

According to the National Institute of Child Health and Human Development, currently there is no definitive, single treatment for the management of ASD. Individuals with ASD have a wide spectrum of behaviors and abilities so that no one approach is equally effective for all, and not all individuals in outcome studies have benefited to the same degree. In addition, individuals with ASD may require new and/or multiple episodes of care or modifications to the frequency and duration of existing services. These changes are typically based on re-examination due to the severity of the current condition, as well as changes related to growth and development, caregivers, environment, or functional demands. The primary goals of management of ASD are to minimize the core features and associated deficits, maximize functional independence and quality of life, and alleviate family distress (Myers et al, 2007). Early Intensive Behavioral Interventions (including ABA) have not been as well studied in children with early childhood developmental disorders other than ASD. However, considering the significant comorbidity of moderate and severe intellectual disabilities with ASD, it is possible that ABA will be somewhat effective in individuals in this population, even without the diagnosis of ASD.

INTELLECTUAL DISABILITY

Intellectual disability refers to deficits in intellectual and adaptive functioning, which is observed during development. Intellectual functioning includes the ability to reason, problem solve, plan, think abstractly, exercise judgement, and learn. Adaptive functioning refers to the skills needed to live in an independent and responsible manner, including communication, social skills, and self-help skills, such as dressing, feeding, money management, and shopping.

SEVERITY LEVELS	Indications
Level 4 – Profound	• IQ less than 20* • Significant developmental delays in all areas • Obvious physical and congenital abnormalities • Requires direct supervision
Level 3 – Severe	• IQ of 20-34* • Considerable delays in development • Understands speech, but little ability to communicate • Able to learn daily routines • May learn very simple self-care • Needs direct supervision in social situations
Level 2 – Moderate	• IQ of 35-49* • Noticeable developmental delays (i.e., speech, motor skills) • May have physical signs of impairment (i.e., thick tongue) • Can communicate in basic, simple ways • Able to learn basic health and safety skills • Can complete self-care activities • Can travel alone to nearby, familiar places
Level 1 – Mild	• IQ of 50 – 70* • Slower than typical in all developmental areas • No unusual physical characteristics • Able to learn practical life skills • Attains reading and math skills up to grade levels 3 to 6 • Able to blend in socially • Functions in daily life

* **Note:** According to the DSM-5, the categories of 'mild, moderate, severe, and profound' are not directly correlated with specific IQ scores, and are better categorized according to adaptive functioning in the conceptual, social, and practical domains. IQ scores should therefore only be used as a guide and not to directly establish level of severity.

This policy does not cover the diagnosis of mild intellectual disability (without ASD), as these individuals often possess sufficient social skills and language skills to respond to less intensive operant conditioning behavioral strategies and likely do not require ABA.

Policy

Coding Information

Click the links below for attachments, coding tables & instruction

Attachment I- CPT® Code List & Instructions

Attachment II- ICD-10-CM Code List & Instructions

The intent of this policy is to communicate the medical necessity criteria for Applied Behavior Analysis (ABA) in members diagnosed with ASD and/or moderate or severe intellectual disability

When a service may be considered medically necessary

Adaptive Behavior Assessment Services
ABA assessment services may be considered **medical necessary** when the following criteria are met:

- Documented attempt to obtain records from any prior ASD evaluations and/or treatments; **AND**

- Documentation from the primary care provider, psychiatrist, or psychologist that the member has a diagnosis of autism spectrum disorder, as assessed by, including but not limited to, one of the following: (the Childhood Autism Rating Scale, he Autism Diagnostic Observation Schedule, the Autism Diagnostic Interview-Revised, and /or the Gilliam Autism Rating Scale) or is diagnosed with moderate or severe intellectual disability based on the criteria set forth in DSM-5 (see Attachment II for applicable ICD-10-CM diagnosis codes); **AND**

- If the diagnosis is Intellectual Disability, the findings of an official
    - psychologist's report stating that the patient has Moderate or Severe Intellectual Disability, including standardized intelligence testing conducted to determine the level of intellectual disability; **AND**

- An assessment of the severity of the Autism Spectrum Disorder according to DSM-5; (as assessed using standardized assessments, such as the Childhood Autism Rating Scale, the Autism Diagnostic Observation Schedule, the Autism Diagnostic Interview-Revised, and/or the Gilliam Autism Rating Scale); **AND**

- Documentation of the social /educational supports that the member is currently receiving (such as one-on-one aide in school).

NOTE: Components of this evaluation may be conducted by a Board -Certified Assistant Behavior Analyst (BCaBA), however the evaluation must be reviewed by a Board- Certified Behavior Analyst (BCBA). See Provider Types for ABA Services in the policy.

Adaptive Behavior Treatment Services

ABA therapy may be considered medically necessary when the following criteria have been identified and documented:

1. The member has a diagnosis of Autism Spectrum Disorder and/or moderate or severe intellectual disability; **AND**

2. Less intensive behavioral treatment/therapy has been considered or has been ineffective; **AND**

3. ASD and/or moderate or severe intellectual disability is adversely affecting the member's development, communication, social interactions, or behavior such that the member is unable to adequately participate in age-appropriate home, school, or community activities, or the member is a safety risk to self, others, or property; **AND**

4. Treatment protocols are implemented, and data is collected relating to each treatment goal. Progress in individual goals is documented **AND**

5. When appropriate, ABA therapy service treatment goals are coordinated with treatment goals in other settings, such as school; **AND**

6. Hours requested for treatment per service are listed and are within the parameters set forth in this policy (see coding table below for maximum units/hours allowed for each service type); **AND**

7. ABA hours provided per this policy will be for time of treatment outside of the school setting (i.e., home or office setting), so that the school is responsible for ABA provided by an aide throughout the school day. For example, if direct 1:1 ABA service is approved by Blue Cross VT, it is likely that the member would benefit from ABA being provided in the school setting as well.

Continued Adaptive Behavior Treatment Services

For continued ABA services to be considered medically necessary, the following criteria must be met:

1. The member continues to meet criteria defined in the above section (ABA medical necessity criteria); **AND**

2. There is evaluation of progress, including data on targeted symptoms and behaviors is collected by direct therapy providers; **AND**

3. Treatment does not appear to be negatively impacting the member or causing symptoms to become persistently worse; **AND**

4. The member continues to achieve treatment goals; **AND**

5. The member demonstrates the ability to maintain long-term gains from the proposed plan of treatment; **AND**

6. The member continues to demonstrate progress towards goals over successive authorization periods as indicated below. If progress towards treatment goals is not being demonstrated, there must be evidence that the treatment plan is being adjusted. Targeted behaviors are graphed and a VB-MAPP Transition Scoring Form or an alternative acceptable assessment (e.g., the Assessment of Functional Living Skills or Essential for Living Skills) is completed (improvements are from baseline to specific endpoint as indicated):

    - Five to six months from baseline:
        - There is at least a 20 percent decline in negative ("exposure ABA") behaviors from the first month of collecting data, as evidenced by focused goal graph charting, and/or
        - There is at least a 20 percent increase in positive ("adaptive ABA") behaviors from the first month of collecting data, as evidenced by focused goal graph charting.

    - Eleven to twelve months from baseline:
        - There is at least a 40 percent decline in negative ("exposure ABA") behaviors from the first month of collecting data, as evidenced by focused goal graph charting, and/or
        - There is at least a 40 percent increase in positive ("adaptive ABA") behaviors from the first month of collecting data, as evidenced by focused goal graph charting.

    - Seventeen to Eighteen months and beyond from baseline:
        - There is at least a 75 percent decline in negative ("exposure ABA") behaviors from the first month of collecting data, as evidenced by focused goal graph charting, and/or
        - There is at least a 75 percent increase in positive ("adaptive ABA") behaviors from the first month of collecting data, as evidenced by focused goal graph charting.

When a service is considered not medically necessary

The following services are considered **not medically necessary,** including but not limited to:

1. When treatment is making symptoms or negative behavior(s) persistently worse; When no meaningful, measurable change has been documented in the individual's functioning and/or behavior(s) for a period of at least six months of optimal treatment;

2. When the individual has achieved adequate stabilization of functions and/or the challenging behavior(s), and less-intensive modes of treatment are appropriate. (It is appropriate to request to restart treatment if measurable deterioration in functioning

and/or behavior(s) occurs with less intensive modes of treatment);

3. When the individual's parent(s) and/or caregiver(s) demonstrate adequate skill in administering a long-term home-based program;

4. When the individual demonstrates an inability to maintain long-term gains from the proposed treatment plan;

5. When more than one program manager/lead behavioral therapist is providing ABA services for a member at any one time;

6. When more than one provider group/clinic/agency/organization is providing ABA services for a member at any one time;

7. When more than one clinician (program managers/lead behavioral therapists, or therapy assistants/behavioral technicians/paraprofessionals, or program manager/lead behavioral therapist and therapy assistant/behavioral technician/paraprofessional) is providing direct (ABA) treatment services to the same member at the same time;

8. When ABA treatment and a different type of treatment (e.g., ABA and speech therapy) are provided to the same identified member at the same time. [Individuals with ASD cannot adequately focus on and engage in two different treatment modalities simultaneously];

9. When ABA direct treatment services are provided to more than one identified member in the same treatment session (With the exception of social skills group).

When a service is considered investigational

ABA treatment services beyond the maximum/allowable units as outlined within this policy are considered investigational.

When a service is considered a benefit exclusion and therefore not covered

1. Services beyond those needed to restore the ability to perform Activities of Daily Living or to establish or re-establish the capability to perform occupational, hobby, sport or leisure activities;

2. Care for which there is no therapeutic benefit or likelihood of improvement;

3. Education, educational evaluation or therapy, therapeutic boarding schools, services

that should be covered as part of an evaluation for, or inclusion in, a child's individualized education plan (IEP) or other educational program;

4. Support therapies, including pastoral counseling, assertiveness training, dream therapy, hippotherapy, music or art therapy, recreational therapy, tobacco cessation support therapy, stress management, wilderness programs, therapy camps, adventure therapy and bright light therapy.

Provider Types for ABA Services

ABA services are either provided by, or are performed under the supervision of, a clinician (often referred to as the program manager or lead behavioral therapist) who is one of the following:

- A Board-Certified Behavior Analyst (BCBA), certified by the Behavior where required.
- Any other state-licensed or certified behavior instructor (BI).
- Any other provider whose legally permitted scope of practice includes behavior analysis.

Note: A Board-Certified assistant Behavior Analyst (BCaBA) or a state-licensed Assistant Behavior Analyst may *not* function as a program manager or lead behavioral therapist and may *not* provide ABA services without supervision.

Reference Resources

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20. 8.V.S.A.§4088i. Available at: https://law.justia.com/codes/vermont/2012/title08/chapter107/section4088i/. Accessed 22July 2021.
21. Supplemental Guidance on Interpreting and Applying the 2019 CPT Codes for Adaptive Behavior Services. Applied Behavior Analysis International and Board Certification in Behavior Analysis. January, 2019.
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Document Precedence

Blue Cross and Blue Shield of Vermont (Blue Cross VT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer's benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, Blue Cross VT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, Blue Cross VT reserves the right to recoup all non- compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval is not required and benefits are subject to all terms, limitations and conditions of the subscriber contract.

Incomplete authorization requests may result in a delay of decision pending submission of missing information. To be considered compete, see policy guidelines above.

NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member's health plan.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in

the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

07/2011	New Policy
11/2013	ICD-10 remediated. Age requirement changed to: up to 21 years. Non-covered section (including exclusions) added pg.14.
02/2015	Cat III codes and clinical criteria for ABA services added. Diagnosis codes for Moderate and Severe intellectual disability added. Clarification on Genetic Testing added. Reviewed & approved by MPC Jan. 2015.
09/2018	1. Title changed to "Applied Behavior Analysis (ABA)" 2. All sections of policy not specific to ABA were removed 3. Updated descriptions of Autism Spectrum Disorder (ASD) and Intellectual Disability to align with ICD-10 / DSM 5 4. Removed section on screening and evaluation of ASD 5. Updated section on requirements of initial Behavior Identification Assessment 6. Updated medical necessity criteria for initial ABA and continuation of ABA services; align with State of VT guidelines 7. Added section listing required documents to be submitted with prior authorization request for initial ABA services and for continued ABA services 8. Changed number of allowable units for each procedure code 9. Updated procedure code list, diagnosis codes (Attachments I and II) 10. Added Attachment III (Treatment Recommendations Worksheet Coding reviewed all codes and codes removed have been reconciled to be aligned with appropriate policies. The codes presented in this policy (0360T, 0361T, 0362T, 0363T, 0364T, 0365T, 0368T, 0369T, 0370T, 0371T, 0373T, 0374T) require PA. ICD 9-CM table removed and updated with ICD-10 -CM table
01/2019	Effective 01/01/2019 Adaptive Maintenance Review with the following changes: Summary of changes effective 01/01/2019: The following codes have been **Deleted Codes**: 0359T, 0360T, 0361T, 0363T, 0364T, 0365T, 0366T, 0367T, 0368T, 0369T, 0370T, 0371T, 0372T, 0374T. **Revised codes**: 0362T & 0373T. **New Codes**: 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158.

01/2019	Coding Summary: Revised the following on Attachment III: Updated the codes 0362T & 0373T descriptors effective 01/01/2019. Added codes 97154 & 97158 effective 01/01/2019 to the worksheet. Revised language under Applied Behavior analysis for Treatment of ASD section. Updated references.
05/2019	Updated the maximum hours/ units allowed for code 97155. Updated references.
07/2021	Revised Autism Spectrum Services for members, beginning at birth and continuing until the member reaches age 21. Updated reference.
04/2025	Updated policy with several language clarifications and modifications based on expert specialty feedback. Inserted additional information regarding when services may not be medically necessary. Added section and language regarding when ABA services are considered investigational (units beyond maximum plan allowance). Updated references. Removed prior approval requirement on codes: 0362T, 0373T, 97152, 97153, 97154, 97155, 97156, 97157, 97158. Updated allowable hours/units per plan year. Removal of age limit of 21 years.

Eligible providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by Blue Cross VT Medical Directors

Tom Weigel, MD, MBA
Vice President & Chief Medical Officer

Tammaji P. Kulkarni, MD
Senior Medical Director

Attachment I

CPT® Code List & Instructions

Code	Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.		
0362T	Behavior identification supporting assessment, 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.	**Prior Approval NOT Required** Maximum of 60 hours (240 units) per Plan year. Used for follow-up assessments (supervision services); exposure
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	**Prior Approval NOT Required** maximum of 156 hours (624 units) per Plan year. Used for ABA therapy services; exposure, modified.
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	**Prior Approval NOT Required**
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	**Prior Approval NOT Required** Maximum of 60 hours (240 units) per Plan year. Used for follow-up assessments (supervision services); observational/adaptive

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	**Prior Approval NOT Required** Maximum of 1,560 hours (6,240 units) per Plan year. Used for ABA therapy services; adaptive.
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	**Prior Approval NOT Required** Maximum 72 hours (288 units) per Plan year of codes 97154 and 97158 combined. Used for multi-patient group therapy by technician.
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	**Prior Approval NOT Required** Maximum of 312 hours (1,248 units) per Plan year. Used for ABA therapy services; adaptive, modified.
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes	**Prior Approval NOT Required** Maximum 52 hours (208 units) per Plan year. Used for family adaptive therapy.
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes	**Prior Approval NOT Required** Maximum 52 hours (208 units) per Plan year. Used for multi-family group therapy, without the patient present.
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	**Prior Approval NOT Required** Maximum 72 hours (288 units) per Plan year of codes 97154 and 97158 combined. Used for multi-patient group therapy by physician or QHCP.

Attachment II

ICD-10-CM Code List & Instructions

Code Type	Number	Description	
The following diagnosis codes will be considered as medically necessary when applicable criteria have been met.			
ICD-10-CM	F71	Intellectual Disability- Moderate	
ICD-10-CM	F72	Intellectual Disability- Severe	
ICD-10-CM	F84.0	Autistic Disorder	
ICD-10-CM	F84.2	Rett's Syndrome	
ICD-10-CM	F84.3	Other Childhood Disintegrative Disorder	
ICD-10-CM	F84.5	Asperger's Syndrome	
ICD-10-CM	F84.8	Other Pervasive Developmental Disorders	
ICD-10-CM	F84.9	Pervasive Developmental Disorder, Unspecified	