



## NEW DIRECTIONS BEHAVIORAL HEALTH, L.L.C.

Medical Policy	Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder
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**Original Effective date:** 03/19/15

**Reviewed:**

**Revised:** 09/01/2015, 1/1/2016, 1/10/2017, 10/25/2017, 9/26/2018, 12/12/2018, 9/12/2019

**PURPOSE:** To provide practice parameters for managing service requests for Applied Behavior Analysis to treat members with Autism Spectrum Disorder so that benefits are applied in a consistent and relevant fashion.

### OVERVIEW:

New Directions Behavioral Health® manages Applied Behavior Analysis (ABA) benefits for various health plans. This medical policy is used to review and make benefit decisions for ABA service requests for members with the diagnosis of Autism Spectrum Disorder (ASD).

ASD is a medical, neurobiological, developmental disorder, characterized by Core Deficit areas: persistent deficits in social communication and social interaction across multiple contexts AND, restricted, repetitive patterns of behavior, interests, and activities. Diagnostic and Statistical Manual fifth edition (DSM-5) requires all of these symptoms to be present in early development, and further specifies clinically significant impairment in social, occupational or other important areas of current function. Benefit coverage for behavioral therapies to treat symptoms of ASD is driven by individual state mandates. Health plans for which New Directions currently administers the ASD benefit may consider ABA to be experimental/investigational and therefore a non-covered service without a controlling state mandate. In addition, large self-funded accounts may provide a benefit for ABA in ASD. These are not typically subject to mandate language.

ABA is the behavioral treatment approach most commonly used with children with ASD. The defining characteristics of ABA are applied, behavioral, analytic, technological, conceptually systematic, effective and capable of appropriately generalized outcomes.

ABA involves a structured environment, predictable routines, individualized treatment, transition and aftercare planning, and significant family involvement. ABA attempts to increase skills related to behavioral deficits and reduce behavioral excesses including eliminating barriers to learning. Behavioral deficits may occur in the areas of communication, social and adaptive skills, but are possible in other areas as well. Examples of deficits may include: a lack of expressive language, inability to request items

or actions, limited eye contact with others, and inability to engage in age-appropriate self-help skills such as tooth brushing or dressing. Examples of behavioral excesses may include, but are not limited to: physical aggression, property destruction, elopement, self-stimulatory behavior, self-injurious behavior, and vocal stereotypy.

At an initial assessment, target symptoms are identified. A treatment plan is developed that identifies the core deficits and aberrant behaviors, and includes designated interventions intended to address these deficits and behaviors and achieve individualized goals. Treatment plans are usually reviewed for medical necessity (defined below) twice annually (frequency dependent upon the controlling state mandate) to allow re-assessment and to document treatment progress

A Functional Behavioral Assessment (FBA) may also be a part of any assessment. A FBA consists of

- a. Description of the problematic behavior (topography, onset/offset, cycle, intensity, severity)
- b. History of the problematic behavior (long-term and recent)
- c. Antecedent analysis (setting, people, time of day, events)
- d. Consequence analysis
- e. Impression and analysis of the function of the problematic behavior

## **MEDICAL NECESSITY:**

These criteria will be applied to all service requests received by New Directions Autism Resource Program.

New Directions defines “Medical Necessity” or “Medically Necessary” as health care services rendered by a provider exercising prudent clinical judgment, which are:

- A. Consistent with:
  1. The evaluation, diagnosis, prevention, treatment or alleviation of symptoms of an illness, disease or injury defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM)
  2. Generally accepted standards of medical practice, as defined by credible scientific evidence published in peer-reviewed medical literature, which are generally recognized by the appropriate medical community, Physician Specialty Society recommendations and other relevant factors
- B. Clinically appropriate and designed to meet the individualized needs of the patient with regard to type, frequency, extent, site and duration of services
- C. Considered effective to improve symptoms associated with the patient’s illness, disease, injury or deficits in functioning
- D. Provided at the least restrictive and most clinically appropriate service or level of care to safely, effectively, and efficiently meet the needs of the patient
- E. Required for reasons other than the convenience of the patient, family/support system, physician or other health care provider
- F. Not a substitute for non-treatment services addressing environmental factors
- G. Not more costly than an alternative service or services, which are at least as likely to produce equivalent diagnostic or therapeutic results for the patient’s illness, disease or injury

## **COVERAGE GUIDELINES: INITIAL SERVICE REQUEST**

New Directions may authorize ABA services for ASD only if all of the following criteria are met:

### **COMPREHENSIVE DIAGNOSTIC EVALUATION:**

1. The member has a diagnosis of Autism Spectrum Disorder (ASD) from a clinician who is licensed and qualified to make such a diagnosis. Such clinicians are usually a: neurologist, developmental pediatrician, pediatrician, psychiatrist, licensed clinical psychologist, or medical doctor experienced in the diagnosis of ASD. State mandates may define eligible qualified clinicians;
  - a. Documentation of the diagnosis must be accompanied by a clinical note of sufficient depth that allows concordance with DSMV criteria for core symptoms of ASD
  - b. The comprehensive evaluation must rule out behavior/ medical diagnosis that potentially have similar symptom presentations.
    - i. This includes neurological disorders, hearing disorders, behavior disorders, and other developmental delays
2. Member is within the age range specified in the applicable health plan's member service plan description or in the applicable state mandate for treatment.

### **ABA TREATMENT ASSESSMENT:**

New Directions may authorize an ABA services assessment only if all of the following criteria are met:

1. Diagnostic Criteria as set forth in the current DSM are met;
2. Hours requested are not more than what is required to complete the treatment assessment.
3. For initial ABA treatment assessment, the following baseline data must have been completed prior to or scheduled to be completed within 90 days of the assessment and be less than 5 years old
  - a. developmental and cognitive evaluation
  - b. autism specific assessment that identifies the severity of the condition
  - c. adaptive behavior assessment completed within 8 months of start date of treatment
  - d. Neurological Evaluation
  - e. information applicable to state mandate

Note: Only CPT codes identified in this document will be approved for the ABA assessment process. Standardized psychological testing services are billed with specific psychological testing AMA-CPT code by eligible providers. Typically, a clinical psychologist is qualified to provide testing services.

### **INITIAL ABA SERVICE TREATMENT REQUEST:**

New Directions may authorize the initiation of ABA services for ASD only if all of the following criteria are met:

1. Diagnostic Criteria as set forth in the DSM-5 are met;
2. ABA services do not duplicate services that directly support academic achievement goals that may be included in the member's educational setting or the academic goals encompassed in the member's Individualized Education Plan (IEP)/Individualized Service Plan (ISP). This includes

shadow, para-professional, interpersonal or companion services in any setting that are implemented to directly support academic achievement goals;

3. The ABA services recommended do not duplicate services provided or available to the member by other medical or behavioral health professionals. Examples include but are not limited to behavioral health treatment such as individual, group, and family therapies; occupational, physical, and speech therapies;
4. Approved treatment goals and clinical documentation must be focused on active ASD core symptoms, substantial deficits that inhibit daily functioning, and clinically significant aberrant behaviors. This includes a plan for stimulus and response generalization in novel contexts;
5. When there is a history of ABA treatment, the provider reviews the previous ABA treatment record to determine that there is a reasonable expectation that a member has the capacity to learn and generalize skills to assist in his or her independence and functional improvements.
6. For comprehensive treatment, the requested ABA services are focused on reducing the gap between the member's chronological and developmental ages such that the member is able to develop or restore function to the maximum extent practical

OR

For focused treatment, the requested ABA services are designed to reduce the burden of selected targeted symptoms on the member, family and other significant people in the environment, and to target increases in appropriate alternative behaviors;

7. Treatment intensity does not exceed the member's functional ability to participate;
8. Hours per week requested are not more than what is required to achieve the goals listed in the treatment plan and must reflect the member's, caregiver's, and provider's availability to participate in treatment;
9. A complete medical record is submitted by the Board Certified Behavior Analyst (BCBA) to include:
  - a. All initial assessments performed by the BCBA and must utilize direct observation. Preferred skills assessments must be developmentally and age appropriate and include non-standardized assessments such as the ABLLS, VB-MAPP, or other developmental measurements employed. Only those portions of assessments that address core deficits of autism are reimbursable; this excludes assessments or portions of assessments that cover academic, speech, vocational deficits, etc. Please note that standardized adaptive behavior assessment tools are not accepted as skills assessment tools;
  - b. Individualized treatment plan with clinically significant and measurable goals that clearly address the active symptoms and signs of the member's core deficits of ASD;
  - c. Goals should be written with measurable criteria such that they can be reasonably achieved within six months;
  - d. Goals should include: documentation of core symptoms of ASD in the treatment plan, date of treatment introduction, measured baseline/present level of performance of the targeted goal, objective present level of behavior, mastery criteria, estimated date of mastery, and a specific plan for generalization of skills;
  - e. Functional Behavior Assessment to address targeted problematic behaviors with operational definition and provide data to measure progress, as clinically indicated;

- f. Documentation of treatment participants, procedures and setting;
  - g. Coordination of care with member's other treating providers to communicate pertinent medical and/or behavioral health information.
10. Direct line therapy services are provided by a Registered Behavior Technician (RBT), or Board Certified Assistant Behavior Analyst (BCaBA), supervised by a BCBA or Doctoral level BCBA (BCBA-D), or provided in a manner consistent with the controlling state mandate. In selected circumstances, New Directions will consider direct 1:1 services provided by a BCBA or BCBA-D;
  11. Telehealth/ Telemedicine is not an approved method of service delivery for direct ABA services. Telehealth/ Telemedicine for parent education and direct supervision activities can be covered if allowed as an eligible telehealth/ telemedicine service under the member benefit plan. It is recommended that telehealth/ telemedicine service delivery be combined with face to face service delivery of direct supervision activities.
  12. Caregiver participation in at least 80 percent of scheduled caregiver training sessions. Caregiver training is defined as the education and development of caregiver-mediated ABA strategies, protocols, or techniques directed at facilitating, improving, or generalizing social interaction, skill acquisition and behavior management, to include observational measures for assurance of treatment integrity. Caregiver training is necessary to address member's appropriate generalization of skills, including activities of daily living, and to potentially decrease familial stressors by increasing member's independence. Caregiver training goals submitted for each authorization period must be specific to the member's identified needs and should include goal mastery criteria, data collection and behavior management procedures if applicable, and procedures to address ABA principles such as reinforcement, prompting, fading, and shaping. Each goal should include date of introduction, current performance level, and a specific plan for generalization. It is recommended that one hour of caregiver training occurs for the first 10 hours of direct line therapy, with an additional 0.5 hours for every additional 10 hours of scheduled direct line therapy unless contraindicated or caregiver declines. Caregiver training hours should increase to a higher ratio of total direct line therapy hours as increased number of member goals address activities of daily living, as provider plans for transition to lower level of care within the next 6 months or as member comes within one year of termination of benefits based on policy benefit restrictions. Clinical rationale must be provided when less than 80 percent participation in scheduled caregiver training sessions occurs during a review period to address any deficits in member generalization of acquired skills into non-clinical community settings. Caregiver training does not include training of teachers, other school staff, other health professionals or other counselors or trainers in ABA techniques.
  13. Although not required for the initial service request, transition and aftercare planning should begin during the early phases of treatment.

## **COVERAGE GUIDELINES: CONTINUED SERVICE REQUEST**

New Directions may authorize continued ABA treatment services for ASD only if all of the following criteria are met:

1. Diagnostic Criteria as set forth in the DSM-5 are met;

2. ABA services do not duplicate services that directly support academic achievement goals that may be included in the member's educational setting or the academic goals encompassed in the member's IEP/ISP. This includes shadow, para-professional, interpersonal or companion services in any setting that are implemented to directly support academic achievement goals
3. The ABA services recommended do not duplicate services provided or available to the member by other medical or behavioral health professionals. Examples include but are not limited to behavioral health treatment such as individual, group, and family therapies; occupational, physical, and speech therapies;
4. Approved treatment goals and clinical documentation must be focused on active ASD core symptoms, substantial deficits that inhibit daily functioning, and clinically significant aberrant behavior. This includes a plan for stimulus and response generalization in novel contexts;
5. Adaptive Behavior Testing (such as the Vineland Adaptive Behavior Scale (VABS), and Adaptive Behavior Assessment System (ABAS), Behavior Assessment System for Children: Adaptive Skills (BASC 3), Pervasive Developmental Disorder Behavior Inventory (PDDBI) annually within a 45-day period of the next scheduled concurrent review. The Vineland or other standardized psychological tests may be required on any concurrent review dependent on clinical information obtained during the course of ABA treatment;
6. For comprehensive treatment, the requested ABA services are focused on reducing the gap between the member's chronological and developmental ages such that the member is able to develop or restore function to the maximum extent practical

OR

For focused treatment the requested ABA services are designed to reduce the burden of selected targeted symptoms on the member, family and other significant people in the environment, and to target increases in appropriate alternative behaviors;

7. Treatment intensity does not exceed the member's functional ability to participate;
8. Hours per week requested are not more than what is required to achieve the goals listed in the treatment plan and must reflect the member's, caregiver's, and provider's availability to participate in treatment;
9. A complete medical record is submitted by the BCBA to include:
  - a. Collected data, including additional non-standardized testing such as ABLLS, VB-MAPP or other developmentally appropriate assessments, celeration charts, graphs, progress notes that link to interventions of specific treatment plan goals/objectives. Only those portions of assessments that address core deficits of autism are reimbursable; this excludes assessments or portions of assessments that cover academic, speech, vocational deficits, etc.;
  - b. Individualized treatment plan with clinically significant and measurable goals that clearly address the active symptoms and signs of the member's core deficits of ASD;
  - c. Goals should be written with measurable criteria such that they can be reasonably achieved within six months;
  - d. Goals should include documentation of core symptoms of ASD identified on the treatment plan, date of treatment introduction, measured baseline of targeted goal, objective present level of behavior, mastery criteria, estimated date of mastery, a

specific plan for Generalization of skills, and the number of hours per week estimated to achieve each goal;

- e. Functional Behavior Assessment to address targeted problematic behaviors with operational definition and provide data to measure progress, as clinically indicated;
  - f. Documentation of treatment participants, procedures and setting;
  - g. Coordination of care with member's other treating providers to communicate pertinent medical and/or behavioral health information.
- 10. Direct line therapy services are provided by a line therapist, or RBT, or BCaBA, supervised by a BCBA or BCBA-D, or the provision of services is consistent with the controlling state mandate. In selected circumstances, New Directions will consider direct one to one services provided by a BCBA or BCBA-D;
- 11. Telehealth/ Telemedicine is not an approved method of service delivery for direct ABA services. Telehealth/ Telemedicine for parent education and direct supervision activities can be covered if allowed as an eligible telehealth/ telemedicine service under the member benefit plan. It is recommended that telehealth/ telemedicine service delivery be combined with face to face service delivery of direct supervision activities.
- 12. On concurrent review, the current ABA treatment demonstrates significant improvement and clinically significant progress to develop or restore the function of the member.
  - a. Significant improvement is mastery of a minimum of 50 percent of stated goals found in the submitted treatment plan. New Directions may request further psychological testing be obtained to clarify limited/lack of treatment response. Adaptive behavior, cognitive and/or language testing must show evidence of measureable functional improvement, as opposed to declining or plateaued scores. For members who do not master 50 percent of stated goals and/or fail to demonstrate measurable and substantial evidence toward developing or restoring the maximum function of the member, the treatment plan should clearly address the barriers to treatment success;
  - b. There is reasonable expectations of mastery of proposed goals within the requested six-month treatment period and that achievement of goals will assist in the member's independence and functional improvements;
  - c. If six month goals are continued into the next treatment plan, these goals must be connected to long term goals that are clinically significant and with a reasonable expectation of mastery.
  - d. There is a reasonable expectation that a member is able to, or demonstrates the capacity to, acquire and develop clinically significant generalized skills to assist in his or her independence and functional improvement to reduce the need for custodial, respite, interpersonal or paraprofessional care or other support services
  - e. If the member does not demonstrate significant improvement or progress achieving goals for successive authorization periods, benefit coverage of ABA services may be reduced or denied;
- 13. Caregiver participation in at least 80 percent of scheduled caregiver training sessions. Caregiver training is defined as the education and development of caregiver-mediated ABA strategies, protocols, or techniques directed at facilitating, improving, or generalizing social interaction,

skill acquisition and behavior management, to include observational measures for assurance of treatment integrity. Caregiver training is necessary to address member's appropriate generalization of skills, including activities of daily living, and to potentially decrease familial stressors by increasing member's independence. Caregiver training goals submitted for each authorization period must be specific to the member's identified needs and should include goal mastery criteria, data collection and behavior management procedures if applicable, and procedures to address ABA principles such as reinforcement, prompting, fading, and shaping. Each goal should include date of introduction, current performance level, and a specific plan for generalization. It is recommended that one hour of caregiver training occurs for the first 10 hours of direct line therapy, with an additional 0.5 hours for every additional 10 hours of scheduled direct line therapy unless contraindicated or caregiver declines. Caregiver training hours should increase to a higher ratio of total direct line therapy hours as increased number of member goals address activities of daily living, as provider plans for transition to lower level of care within the next 6 months or as member comes within one year of termination of benefits based on policy benefit restrictions. Clinical rationale must be provided when less than 80 percent participation in scheduled caregiver training sessions occurs during a review period to address any deficits in member generalization of acquired skills into non-clinical community settings; Caregiver training does not include training of teachers, other school staff, other health professionals or other counselors or trainers in ABA techniques.

**14.** Transition and aftercare planning should begin during the early phases of treatment. Transition planning should focus on the skills and supports required for the member to transition into their normal environment as appropriate to their achieved and realistic developmental ability. The aftercare planning includes the identification of appropriate services and supports for the time period following ABA treatment. The planning process and documentation should include active involvement and collaboration with a multidisciplinary team. Goals must be developed specifically for the individual with ASD, be functional in nature, and focus on skills needed in current and future environments. The following information should be included:

- Specific skills essential for both the family and member to succeed and how they are actively being addressed.
- A detailed strategy for moving to less intensive ABA care detailing how hours will be faded connected to measurable objectives for family and member.
- The identification of appropriate community resources for the time period following ABA treatment to help support the family.
- The identification of appropriate community resources to support the member's ability to generalize skills to various environments.

Please refer to Guidelines for Treatment Record Documentation section of New Directions' Provider Manual for rules on client file documentation.



New Directions will review requests for ABA treatment benefit coverage based upon clinical information submitted by the provider.

### **SERVICE INTENSITY CLASSIFICATION:**

Comprehensive treatments range from 25 to 40 total hours of direct services weekly. However, New Directions will review each request on an individual basis for fidelity to medical necessity and approve total hours based on the member's severity, intensity, frequency of symptoms, and response to previous and current ABA treatment. Comprehensive treatment includes direct 1:1 ABA, caregiver training, supervision and treatment planning.

Comprehensive ABA treatment targets members whose treatment plans address deficits in all of the core symptoms of Autism. Appropriate examples of comprehensive treatment include: early intensive behavioral intervention and treatment programs for older children with aberrant behaviors across multiple settings. This treatment level, which requires very substantial support, should initially occur in a structured setting with 1:1 staffing and should advance to a least restrictive environment and small group format. Caregiver training is an essential component of Comprehensive ABA treatment. This treatment is primarily directed to children ages 3 to 8 years old because Comprehensive ABA treatment has been shown to be most effective with this population in current medical literature.

Focused treatments range from 10 to 25 total hours of direct services per week. However, New Directions will review each request on an individual basis for fidelity to medical necessity and approve total hours based on the member's severity, intensity, frequency of symptoms and response to previous and current ABA treatment. This treatment may include caregiver training as the only component.

Focused treatment typically targets a limited number of behavior goals requiring substantial support. Behavioral targets include marked deficits in social communication skills and restricted, repetitive behavior such as difficulties coping with change. In cases of specific aberrant and/or restricted, repetitive behaviors, attention to prioritization of skills is necessary to prevent and offset exacerbation of these behaviors, and to teach new skill sets. Identified aberrant behaviors should be addressed with specific procedures outlined in a Behavior Intervention Plan. Emphasis is placed on group work and caregiver training to assist the member in developing and enhancing his/her participation in family and community life, and developing appropriate adaptive, social or functional skills in the least restrictive environment.

Requested treatment hours outside of the range for Comprehensive or Focused treatment will require a specific clinical rationale.

### **HOURS TO BE AUTHORIZED:**

Total authorized hours will be determined based on all of the following:

- The current medical policy and medical necessity
- Provider treatment plan, that identifies suitable behaviors for treatment and improves the functional ability across multiple contexts
- Severity of symptoms, including aberrant behaviors
- Continued measurable treatment gains and response to previous and current ABA treatment.

- Hours per week requested are not more than what is required to achieve the goals listed in the treatment plan and must reflect the member's, caregiver's, and provider's availability to participate in treatment;

## **CASELOAD SIZE:**

The Behavioral Analyst Certification Board's ("BACB") Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers, 2<sup>nd</sup> Edition, [page 35], states that Behavior Analysts should carry a caseload that allows them to provide appropriate case supervision to facilitate effective treatment delivery and ensure consumer protection.

Caseload size for the Behavior Analyst is typically determined by the following factors:

- Complexity and needs of the clients in the caseload
- Total treatment hours delivered to the clients in the caseload
- Total case supervision and clinical direction required by caseload
- Expertise and skills of the Behavior Analyst;
- Location and modality of supervision and treatment (for example, center vs. home, individual vs. group,)
- Availability of support staff for the Behavior Analyst (for example, a BCaBA).

The recommended caseload range for one (1) Behavior Analyst is as follows:

### **Supervising Focused Treatment**

- Without support of a BCaBA is 10 - 15\*
- With support of one (1) BCaBA is 16 - 24\*

Additional BCaBAs permit modest increases in caseloads.

\* Focused treatment for severe problem behavior is complex and requires considerably greater levels of case supervision, which will necessitate smaller caseloads.

### **Supervising Comprehensive Treatment**

- Without support of a BCaBA is 6 - 12
- With support of one (1) BCaBA is 12 - 16

Additional BCaBAs permit modest increases in caseloads.

## **DIAGNOSTIC INSTRUMENTS/ASSESSMENTS:**

These assessments are typically longer, in pronounced detail concerning specific deficits and/or survey a broader swath of core behaviors in autism. Reliability and validity of the instrument are defined in depth. Reliability gauges the extent to which the instrument is free from measurement errors across time, across raters and within the test. Validity is the degree to which other evidence supports inferences drawn from the scores yielded by the instrument. This is often grouped into content, construct and criteria related evidence.

### **Autism Specific Standardized Assessments**

Autism Diagnostic Observation Schedule, second edition. (ADOS-2)  
Autism Diagnostic Interview, revised. (ADI-R)  
Social Responsiveness Scale, second edition. (SRS-2)  
DSM-5 Checklist

**Screening Measures:** These are brief assessments designed to identify children who are in need of a comprehensive evaluation secondary to risks associated with delay, disorder or disease. Screening measures differ from diagnostic measures in that they typically require less time and training to administer. The result indicates the level of risk for disability as opposed to the provision of a diagnosis.

Childhood Autism Rating Scale, second edition. (CARS-2)  
Childhood Autism Spectrum Test. (CAST)  
Social Communications Questionnaire (SCQ)  
Autism Behavior Checklist (ABC)  
Gilliam Autism Rating Scale (GARS)  
Checklist for Autism in Toddlers (CHAT)

### **Other Standardized Assessment Instruments**

Vineland Adaptive behavior Scale (VABS)  
Adaptive Behavior Assessment Scale (ABAS)  
Behavior Assessment System for Children (BASC)  
Pervasive Developmental Disorder Behavior Inventory (PDDBI)

### **Standardized Cognitive Assessments**

Leiter International Performance Scale-R  
Mullen Scales of Early Learning  
Bayley Scales of Infant Development  
Kaufmann Assessment Battery for Children, second edition. (K-ABC-II)  
Wechsler Preschool and Primary Scale of Intelligence, third edition. (WPPSI-III)  
Wechsler Intelligence Scale for Children, fourth edition. (WISC-IV)  
Test of Non-Verbal Intelligence, fourth edition (TONI-4)

## **DEFINITIONS:**

- **Clinically Significant:** Clinical significance is the measurement of practical importance of the treatment effect – whether it creates a meaningful difference and has an impact that is noticeable in daily functioning.
- **Core deficits of Autism:** persistent deficits in social communication and social interaction across multiple contexts AND, restricted, repetitive patterns of behavior, interests, and activities
- **Generalization:** skills acquired in one setting are applied to many contexts, stimuli, materials, people, and/or settings to be practical, useful, and functional for the individual. Generalized behavior change involves systematic planning, and needs to be a central part of every intervention and every caregiver training strategy.

- **Present Level of Performance:** objective and quantitative measures of the percentage, frequency or intensity and duration of skill/behavior prior to intervention
- **Mastery Criteria:** objectively and quantitatively stated percentage, frequency or intensity and duration in which a member must display skill/behavior to be considered an acquired skill/behavior, including generalization and maintenance
- **Functional Behavior Assessment:** comprises descriptive assessment procedures designed to identify environmental events that occur just before and just after occurrences of potential target behaviors and that may influence those behaviors. That information may be gathered by interviewing the member’s caregivers; having caregivers complete checklists, rating scales, or questionnaires; and/ or observing and recording occurrences of target behaviors and environmental events in everyday situations. (AMA CPT, 2019)
- **Neurological Evaluation:** This needs to be completed and documented on every member by a licensed physician as part of the diagnostic evaluation. Any significant abnormalities on the minimal elements of an exam should trigger a referral to a neurologist to perform comprehensive testing to assess neurological abnormalities. Minimal elements include:
  - Evaluation of Cranial nerves I-XII
  - Evaluation of all four extremities, to include motor, sensory and reflex testing
  - Evaluation of coordination
  - Evaluation of facial and/or somatic dysmorphism
  - Evaluation of seizures or seizure like activity
- **Custodial Care:** This is care that does not require access to the full spectrum of services performed by licensed health care professionals that is available 24 hours-a-day in facility-based settings to avoid imminent, serious, medical or psychiatric consequences. In determining whether a person is receiving custodial care, we consider the level of care and medical supervision required and furnished, and whether the treatment is designed to improve or maintain the current level of function. We do not base the decision on diagnosis, type of condition, degree of functional limitation, or rehabilitation potential.

By “facility-based,” we mean services provided in a hospital, extended care facility, skilled nursing facility, residential treatment center (RTC), school, halfway house, group home, or any other facility providing skilled or unskilled treatment or services to individuals whose conditions have been stabilized. Custodial or long-term care can also be provided in the patient’s home, however defined.

Custodial care may include services that a person not medically skilled could perform safely and reasonably with minimal training, or that mainly assist the patient with daily living activities, such as:

1. Personal care, including help in walking, getting in and out of bed, bathing, eating (by spoon, tube or gastrostomy), exercising or dressing
2. Homemaking, such as preparing meals or special diets
3. Moving the patient
4. Acting as companion or sitter
5. Supervising medication that can usually be self-administered

6. Treatment or services that any person can perform with minimal instruction, such as recording pulse, temperature and respiration; or administration and monitoring of feeding systems
- **Respite Care:** care that provides respite for the individual's family or persons caring for the individual
  - **Interpersonal Care:** interventions that do not diagnose or treat a disease, and that provide either improved communication between individuals, or a social interaction replacement
  - **Paraprofessional Care:** services provided by unlicensed persons to help maintain behavior programs designed to allow inclusion of members in structured programs or to support independent living goals except as identified in state mandates or benefit provisions
  - **Non-standardized instruments:** include, but not limited to, curriculum-referenced assessment, stimulus preference- assessment procedures, and other procedures for assessing behaviors and associated environmental events that are specific to the individual patient and behaviors. (AMA CPT, 2019)
  - **Standardized Assessments:** include, but not limited to, behavior checklists, rating scales, and adaptive skill assessment instruments that comprise a fixed set of items and are administered and scored in a uniform way with all patients. (AMA CPT, 2019) The listed assessments are not meant to be exhaustive, but serve as a general guideline to quantify baseline intelligence and adaptive behaviors and when repeated, measure treatment outcomes. The autism specific assessments assist not only in the confirmation of diagnosis but more importantly, in the severity and intensity of the baseline core ASD behaviors.

## **EXCLUSIONS:**

New Directions considers the following to be exceptions to authorizing benefits. However, the member's health plan policy contract will control if a service is eligible to be covered for benefit payments.

- Services that are purely academic or duplicate academic learning in a school setting for a school age member at or below their excepted age and/or grade level
- Services that are not congruent with this medical policy
- Cognitive Therapy or retraining
- Treatment that is considered to be investigational/experimental, including, but not limited to: Auditory Integration Therapy; Facilitated Communication; Higas.hi Schools/Daily Life; Individual Support Program; LEAP; SPELL; Waldon; Hanen; Early Bird; Bright Start; Social Stories; Gentle Teaching; Response Teaching Curriculum and Developmental Intervention Model; Holding therapy; Movement Therapy; Music Therapy; Pet Therapy; Psychoanalysis; Son-Rise Program; Scotopic Sensitivity Training; Sensory Integration Training; Neurotherapy (EEG biofeedback). Benefit plans specifying the coverage of any treatment considered investigational/experimental are not subject to this exclusion

- Respite, shadow, para-professional, or companion services in any setting
- Personal training or life and/or job coaching
- ABA services in residential facilities to replace or augment the facility’s behavioral health or ABA program
- Custodial care with focus on activities of daily living that do not require or have not responded to intensive ABA treatment staff: BCBA, BCBA-D, line therapist, RBT, etc.

**State mandates and the controlling health plan may have benefit limitations and exclusions not listed in this medical policy.**

**Diagnostic and Billing Codes**

**ICD-10 Codes**

<b>F84.0</b>	<b>Autistic Disorder</b>
<b>F84.3</b>	<b>Other Childhood Disintegrative Disorder</b>
<b>F84.5</b>	<b>Asperger Disorder</b>
<b>F84.8</b>	<b>Other Pervasive Developmental Disorder</b>
<b>F84.9</b>	<b>Pervasive Developmental Disorder, unspecified</b>

ABA Services that require two or more staff members will only be billed as one service provided by the rendering provider.

**CPT Codes**

All ABA codes are billed in 15 minute units. “If the BCBA or other qualified health care professional personally performs the line technician activities, his or her time engaged in these activities should be included as part of the line technicians time to meet the components of the code.” AMA CPT, 2019

**97151 BEHAVIOR IDENTIFICATION ASSESSMENT**

- Conducted by BCBA or qualified health care professional, includes face-to-face and non-face-to-face components, including:
  - Face-to-face member assessment
  - Review of history of current and past behavioral functioning
  - Review of previous assessments and health records
  - Interview parent/caregiver to further identify and define deficient adaptive or maladaptive behaviors
  - Administration of non-standardized test such as VB-MAPP, ABLLS, EFL

- Interpretation of results
- Discussions of findings and recommendations with primary caregiver(s)
- Preparation of report
- Development of care plan and which may include behavior identification supporting assessment (97152) or behavior identification assessment with four required components (0362T)
- May be reported only once within a six-month interval.
- Additional clinical rationale required for more than 8 hours of this code for the initial assessment and for more than 6 hours for six month reassessments.

#### **97152 BEHAVIOR IDENTIFICATION SUPPORTING ASSESSMENT**

- Face to Face with member
- May include collection of data for functional behavior assessment, functional analysis, or other structured procedures
- Utilized to evaluate deficient adaptive behavior(s) maladaptive behavior(s), or other impaired functioning in the following:
  - Communication: receptive and expressive language, echolalia, lack of pragmatic language, visual understanding, requests and labeling
  - Social behavior: lack of empathy, lack of social reciprocity, little or no functional play skills cooperation, motivation, imitation, play and leisure, and social interactions
  - Ritualistic and repetitive behaviors, self-injurious behaviors, and other aberrant behaviors (property destruction, aggression, elopement, etc.) which do not require the intensity of the 0362T code to asses.
- Line Therapist may complete under direction of BCBA, qualified professional off-site.
- The time that the member is face to face with the line therapist(s) correlates with the physician's or other qualified health care professional's work, which includes: technician direction; analysis of results of testing and data collection; preparation of report and plan of care; and discussion of findings and recommendations with the primary guardian(s)/ caregiver(s).
- Additional clinical rationale required for more than a total 8 hours of the initial assessment and for more than a total of 6 hours for six month reassessments for 97151 and 97152, in any combination of usage.

#### **97153 ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL**

- May be administered by a line therapist
- Face to face with one member
- BCBA or qualified health care provider directs service by:
  - Designing treatment plan goals and objectives
  - Analyzing data
  - Determining whether use of treatment goals and objectives is producing adequate progress

#### **97154 GROUP ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL**

- May be administered by a line therapist
- Face to face with two or more members
- BCBA or qualified health care provider directs service by:
  - Designing treatment plan- goals and objectives
  - Analyzing data
  - Observation of treatment implementation for potential program revision,
  - Determining whether use of treatment goals and objectives is producing adequate progress
- Maximum members per group - 8

**97155 ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL MODIFICATION**

- Administered by BCBA or qualified health care professional
- Face to face with a single member or member and line technician
- Resolves one or more problems with the protocol and may simultaneously direct a line technician in administering the modified protocol while member is present
- Direction to technician without the member present is not reported separately;
- Billing for the time of this activity is allowed only for BCBA or qualified health professional time even if other professional providers are present.

Clinical rationale must be provided for requests that exceed 2 hours of adaptive behavior treatment protocol modification per 10 hours of adaptive behavior treatment by protocol.

Adaptive treatment protocol modification may include the following: design, analysis and edits to antecedent or consequence strategies, individualized behavior plan based on functions maintaining aberrant behavior, inclusion of additional acquisition/replacement skills to current treatment plan or analysis and editing of prompt fading, chaining, differential reinforcement or generalization procedures, which require the expertise of the BCBA.

The following examples would not be considered protocol modification for purposes of billing this code and are part of the 97153 and 97154 codes: conducting preference assessments and altering reinforcement and/or implementation of skill acquisition and behavior reduction programs.

**97156 FAMILY ADAPTIVE BEHAVIOR TREATMENT GUIDANCE**

- Administered by BCBA or qualified health care professional
- Face to face with parents, guardian, and caregiver with or without members present
- Utilized to implement treatment protocols designed to address deficient adaptive or maladaptive behaviors

**97157 MULTIPLE FAMILY GROUP ADAPTIVE BEHAVIOR TREATMENT GUIDANCE**

- Administered by BCBA or qualified health care professional
- Face to face with parents, guardians and/or caregivers of multiple members without members present
- Utilized to implement treatment protocols designed to address deficient adaptive or maladaptive behaviors



- Maximum members per group - 8

This code is typically used during the initial treatment phase to educate and orient families in ABA behavioral nomenclature and techniques

**97158 GROUP ADAPTIVE BEHAVIOR TREATMENT WITH PROTOCOL MODIFICATION**

- Administered by BCBA or qualified health care professional
- Face to face with two or more members
- Member must have direct participation in treatment protocol/interactions in order to meet their own individual treatment goals
- Protocol adjustments are made in real time dynamically during the session
- Maximum members per group – 8

This code entails differentiating prompting methods, instruction, antecedent/consequence strategies, varying goals/skills and reinforcement schedules in real time with multiple members simultaneously

**0362T BEHAVIOR IDENTIFICATION SUPPORTING ASSESSMENT WITH FOUR REQUIRED COMPONENTS**

- On-site direction by BCBA, qualified health care professional
- With the assistance of two or more line therapists/ assistants to assist in treatment protocol with supervision of BCBA, qualified health care professional
- For member who exhibits destructive behavior (eg, elopement, pica, or self-injury requiring medical attention; aggression with injury to other(s); or breaking furniture/walls/ windows)
- Requires safe, structured customized environment with possible use of protective gear and padded room
- Requires clinical rationale for need based on frequency, severity, and intensity of the destructive behaviors

BCBA/qualified health care professional shapes environmental or social contexts to examine triggers, events, cues, responses and consequences linked to maladaptive destructive behaviors.

**0373T ADAPTIVE BEHAVIOR TREATMENT WITH PROTOCOL MODIFICATION WITH FOUR REQUIRED COMPONENTS**

- On-site direction by BCBA, qualified health care professional
- With the assistance of two or more line therapists/ assistants to assist in treatment protocol with supervision of BCBA, qualified health care professional
- For member who exhibits destructive behavior (eg, elopement, pica, or self-injury requiring medical attention; aggression with injury to other(s); or breaking furniture/walls/ windows)
- Requires safe, structured customized environment with possible use of protective gear and padded room
- Requires clinical rationale for need based on frequency, severity, and intensity of the destructive behaviors

Staged environment to teach members appropriate alternative response to severe destructive behaviors. Typically delivered in intensive outpatient, day treatment, or inpatient facility, depending on dangerousness of behavior

**Out of State claims coding:**

ABA service providers who are in network with their local Blue Cross and Blue Shield and who are contracted to utilize ABA service codes different from the approved list will be eligible for reimbursement for service codes that are equivalent to covered ABA service codes listed above. Service codes that are not equivalent to the approved service codes are not eligible for reimbursement. Approval for use of alternate service codes can be requested during the provision of ABA services.

**\*CPT Definition of Time Spent with Patient that is Eligible for Reimbursement:**

Face to Face time for outpatient visits is reimbursable and includes:

1. Time spent with patient
2. Time spent with family
3. Time spent with patient and family

The non-face to face time (activities which may occur before, during or after a visit) is included in the work for each CPT code reimbursement. These non-face to face activities are therefore not eligible for claims submission, independent of face to face time. These non-reimbursable events include such activities as: review of records, arranging further services, communicating with the professionals, the patient or the family through written reports and telephone contact, and other non-face to face activities. (CPT Handbook, 2016)

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