



NEW DIRECTIONS BEHAVIORAL HEALTH, L.L.C.

Medical Policy	Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder
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Reviewed:

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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).

Treatments other than ABA do not fall under the scope of this policy; these services include but are not limited to treatments that are considered to be investigational/experimental, such as Cognitive Training, Auditory Integration Therapy, Facilitated Communication, Higashi 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 and Neurotherapy (EEG biofeedback).

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.

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. An 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:

Medical necessity is defined in the controlling specific health plan and/or group documents.

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 DSM-5 criteria for core symptoms of ASD.
 - b. The comprehensive evaluation must rule out behavior/medical diagnosis that potentially have similar symptom presentations. 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
4. Additional clinical rationale required for more than 8 hours of assessment codes 97151 and 97152 for the initial assessment.

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).
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. ABA services are not a substitute for non-treatment services addressing environmental factors, including shadow, para-professional, support, interpersonal or companion services in any setting.
5. 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.

6. 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.
7. 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.
8. Treatment intensity does not exceed the member's functional ability to participate and/or is not for the convenience of the patient, caregiver, treating provider or other professional.
9. 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.
10. Treatment occurs in the setting(s) where target behaviors are occurring and/or where treatment is likely to have an impact on target behaviors.
11. 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.

12. 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;
13. Telehealth/telemedicine is not an approved method of service delivery for direct ABA services (e.g., 97153, 97154, 0373t). Telehealth/telemedicine for parent education (e.g., 97156 and 97157) and direct supervision activities (e.g., 97155) 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.
14. The treatment plan must include a plan to support the member's ability to generalize skills across stimuli, contexts and individuals, via caregiver training or an appropriate alternative. Provider should be able to demonstrate how instructional control will be transferred to caregivers.
15. 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. Member must show progress in generalizing skills across stimuli, contexts and individuals, via caregiver training or an appropriate alternative. Provider should be able to demonstrate how operational control is being transferred to caregivers.
6. 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.

7. 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.
8. Treatment intensity does not exceed the member's functional ability to participate and/or is not for the convenience of the family.
9. Treatment occurs in the setting(s) where target behaviors are occurring and/or where treatment is likely to have an impact on target behaviors. 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.
10. 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.
11. Direct line therapy services are provided by a line therapist, 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.
12. Telehealth/telemedicine is not an approved method of service delivery for direct ABA services (e.g., 97153, 97154, 0373t). Telehealth/telemedicine for parent education (e.g., 97156 and 97157) and direct supervision activities (e.g., 97155) 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.

- 13.** 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 measurable 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 a reasonable expectation 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. When the mastery criteria have been modified to meet an incremental short-term objective, the overall goal is considered to be "continued."
 - 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.
- 14.** The treatment plan for generalization of skills includes either:
 - a.** A plan for caregiver training that includes assessment of the caregivers' skills, measurable goals for skill acquisition and monitoring of the caregivers' use of skills. Generalization of skills should be assessed during parent/caregiver training to ensure the member can demonstrate skill with caregivers in the natural environment during non-therapeutic times. Documentation may be requested to assess the caregivers' ability to implement treatment plan procedures and recommendations to evaluate the following areas.
 - i.** Member's ability to demonstrate the use of replacement skills and/or reductions in aberrant behavior in natural settings.
 - ii.** Family/caregivers' ability to successfully prompt and teach skills and effectively utilize behavior reduction strategies.
 - iii.** The BCBA clinician can assess treatment effectiveness during non-therapeutic times.
 - b.** An alternative plan if caregiver participation does not result in generalization of skills.

15. Transition and aftercare planning should:

- Begin during the early phases of treatment and will change over time based upon response to treatment and presented needs.
- Focus on the skills and supports required for the member for transitioning toward their natural environment, as appropriate to their realistic developmental abilities.
- Identify appropriate services and supports for the time period following ABA treatment.
- Include a planning process and documentation with active involvement and collaboration with a multidisciplinary team to include caregivers.
- Long term outcomes must be developed specifically for the individual with ASD, be functional in nature, and focus on skills needed in current and future environments.
- Realistic expectations should be set with current treatment plan goals connecting to long term outcomes.

16. Additional clinical rationale required for more than 6 hours for six-month reassessments.

Please refer to Guidelines for Treatment Record Documentation section of New Directions' Provider Manual for standards 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, 2nd 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. These assessments also provide a measure for severity of illness.

Screening Measures: These are brief assessments designed to identify children who need of a comprehensive evaluation secondary to risks associated with delay, disorder or disease that will interfere with normal development. Screening measures differ from diagnostic measures in that they typically require less time and training to administer and have high rates of false positives. Results of screening measures indicate the level of risk for disability as opposed to the provision of a diagnosis. Screening measures are not appropriate standalone support for an autism diagnosis and should be followed up by an in-depth assessment. Additional acceptable documentation includes autism specific standardized assessments, or a detailed clinical note based on the DSM-5 signs and symptoms. Examples of screening measures include:

Autism Spectrum Rating Scale (ASRS), long or short form
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)
MCHAT R F with follow up questions (score 3-7)
MCHAT R without follow up questions (score 8-20)

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

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)

Curricular Assessments

These tools are developed to provide a curriculum-based individual assessment. They are criterion-referenced, as opposed to psychological testing, which is vetted, standardized and norm referenced. The latter provide a pathway to allow comparison of an individual member's score to a norm-referenced mean.

Examples include:

Assessment of Basic Language and Learning Skills (ABLLS)
Verbal Behavior Milestones Assessment and Placement Program (VBMAPP)
PEAK
Essentials For Living (EFL)
Assessment of Functional Living Skills (AFLS)

DEFINITIONS:

- **Caregiver Training**: Caregiver participation is a crucial part of ABA treatment and should begin at the onset of services. Provider's clinical recommendations for amount and type of caregiver training sessions should be mutually agreed upon by caregivers and provider. Caregiver participation is expected for at least 80% of agreed upon caregiver training sessions scheduled between provider and caregiver.
 - a. 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.
 - b. 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 caregiver goal should include date of introduction, current performance level and a specific plan for generalization. Goals should include measurable criteria for the acquisition of specific caregiving skills.
 - c. 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 if 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 benefit coverage.

- d. If parents decline or are unable to participate in caregiver training, a generalization plan should be created to address member's skill generalization across environments and people. Should 80% not be attainable over the course of an authorization period, a plan to increase parent participation should also be included in the request for ongoing care.
 - e. Caregiver training does not include training of teachers, other school staff, other health professionals or other counselors or trainers in ABA techniques. However, caregiver training can include teaching caregivers how to train other professionals or people involved in the member's life.
- **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
- **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)
- **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. When the member accomplishes generalization, this increases the likelihood of completing tasks independently.
- **Interpersonal Care:** interventions that do not diagnose or treat a disease, and that provide either improved communication between individuals, or a social interaction replacement
- **Long-Term Objective:** An objective and measurable goal that details the overall terminal mastery criteria of a skill being taught. Specifically, this terminal mastery criteria will indicate that a member can demonstrate the desired skill across people, places and time, which suggests the skill no longer requires further teaching.
- **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
- **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

- **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)
- **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
- **Present Level of Performance:** objective and quantitative measures of the percentage, frequency or intensity and duration of skill/behavior prior to intervention
- **Respite Care:** care that provides respite for the individual's family or persons caring for the individual
- **Short-Term Objective:** An intermediate, objective and measurable goal that details the incremental increases a member must demonstrate in moving toward the identified Long-Term Objective.
- **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.

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

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

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 healthcare 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 healthcare 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

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 assess.
- 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 healthcare 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 healthcare 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 healthcare 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 healthcare 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.

Only face-to-face time may be billed. Pre/post time including direction of line therapist without the member present and analysis of data collection are included in the valuation of the code reimbursement. The technician's time (97153) may not be billed concurrently and is a component included in the valuation of this code.

97156 FAMILY ADAPTIVE BEHAVIOR TREATMENT GUIDANCE

- Administered by BCBA or qualified healthcare 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 healthcare 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 healthcare 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 healthcare professional
- With the assistance of two or more line therapists/ assistants to assist in treatment protocol with supervision of BCBA, qualified healthcare professional
- For member who exhibits destructive behavior (e.g., 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 healthcare 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 healthcare professional

- With the assistance of two or more line therapists/ assistants to assist in treatment protocol with supervision of BCBA, qualified healthcare professional
- For member who exhibits destructive behavior (e.g., 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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