Clinical Policy: Applied Behavior Analysis

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Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This clinical policy outlines the medical necessity criteria for Applied behavioral Analysis (ABA) services for Silver Summit Health Plan as outlined by the Nevada Department of Health and Human Services.

Applied Behavior Analysis (ABA) is the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvements in human behavior. ABA services include the use of direct observation, measurement, and functional analysis to evaluate the relationship between environmental factors and behavior.[1]

Autism Spectrum Disorder (ASD) is a neurodevelopmental disorder characterized by persistent deficits in social communication and social interaction, along with restricted, repetitive patterns of behavior, interests, or activities. Fetal Alcohol Spectrum Disorders (FASD) are a group of developmental conditions resulting from prenatal alcohol exposure that may impact cognitive functioning, behavior, and adaptive skills.[1]

ABA in no way precludes other treatment interventions such as physical therapy (PT), occupational therapy (OT), and other forms of behavioral therapy, family therapy, and/or medication management.

Policy/Criteria

I. It is the policy of Silver Summit health plan that when a covered benefit, *Applied Behavior Analysis (ABA) services* are **medically necessary,** when all of the following are met:

A. The member/enrollee has a diagnosis of autism spectrum disorder (ASD), fetal alcohol spectrum disorder (FASD), or other developmental conditions for which ABA is recognized as medically necessary;
B. The member/enrollee is medically stable and does not require 24-hour medical/nursing monitoring or procedures provided in a hospital level of care;
C. The member/enrollee exhibits excesses and/or skill deficits of behavior that impedes access to age-appropriate activities in the home or community (i.e., aggression, self-injury, elopement, and/or social interaction, independent living, play and/or communication skills, etc.);
D. Completed Nevada Medicaid Applied Behavior Analysis (ABA) Authorization Request Form (FA-11E)[2];
E. All treatment plan documents (treatment plan, goals, and behavior intervention plan, if submitted separately) include a Health Insurance Portability and Accountability Act (HIPAA) compliant signatures, credentials, and roles of the BCBA/BCBA-D responsible

for the member/enrollee's care, member/enrollee (when age appropriate), parent or legal guardian, and any additional person who reviewed and approved the plan, as applicable;

F. Requested service meets one of the following:
   1. Comprehensive diagnostic evaluation;
   2. Functional Behavior Assessment;
   3. Initiation of ABA treatment requests, meets all the following:
      a. Request is submitted no more than 15 business days prior to and no more than 15 calendar days after the start date of service;
      b. A completed Nevada Medicaid Autism Spectrum Disorder (ASD) Diagnosis Certification for Requesting Initial Applied Behavior Analysis (ABA) Services form(FA-11F)[2], which identifies the diagnostic assessment tools/method used to establish the ASD or FASD diagnosis, includes documentation of one of the following, as applicable:
         ***Note**: Submission of the FA-11F is required for all initial ABA treatment authorization requests, including requests for existing or newly enrolled members/enrollees with SilverSummit Health plan and those transitioning from another insurance provider. After the initial submission, the FA-11F is only required to be resubmitted when there is a change in the primary diagnosis.*
         i. For ASD diagnosis, documentation of the scores from one of the diagnostic tools to confirm an ASD diagnosis:
            a) Autism Diagnostic Observation Schedule/Autism Diagnostic Observation Schedule 2nd edition (ADOS/ADOS-2);
            b) Childhood Autism Rating Scale/ Childhood Autism Rating Scale 2nd edition (CARS/CARS-2);
            c) Gilliam Autism Rating Scale (GARS-3);
         ii. For an FASD diagnosis, documentation identifies the diagnostic system, criteria, and/or assessment method used to determine the specific FASD diagnostic category;
            ***Note**: Explicitly maps out the member/enrollee symptoms to the specific DSM codes.*
         iii. If the DSM criteria or other assessment tools are used as the sole basis for establishing the diagnosis, a formal clinical diagnostic evaluation documents the specific DSM diagnostic criteria is met;
      c. *A comprehensive diagnostic evaluation (CDE)*, completed to confirm an ASD or FASD diagnosis, includes a thorough summary demonstrating the effects of current symptoms on the member/enrollee's functional level in various settings (e.g., with family and/or peers in home, school, and community), specifically in the areas of communication, socialization, restricted/repetitive patterns of behavior, and adaptive functioning and documents all the following:
         ***Note**: The CDE is required only one time to establish the diagnosis.*
         i. If the CDE was conducted more than three years ago, an initial diagnostic interview/evaluation (IDI) has been conducted within 12 months of the authorization request meeting all the following:
            a) Reason member/enrollee is seeking services;
            b) Comprehensive mental status exam that supports the treatment;

c) Current DSM diagnosis, including recommendations for active treatment interventions;
d) History & symptomology consistent with DSM (current version) criteria;
e) Psychiatric treatment history;
f) Assessment of current and past suicide/homicide danger;
g) Level of familial support assessed and involved as indicated;
h) Identified areas for improvement;
i) Assessment of strengths, skills, abilities, motivation;
j) Medical history;
k) All current medications with dosages;

ii. Documents all of the following:
a) Direct observation;
b) Parent/caregiver interview;
c) Results of the evaluation in report format, including all the following:
i.) Developmental history;
ii.) Presenting concerns;
iii.) Evaluators summary of each individual assessment/evaluation instrument;
iv.) Test administered with scores and date completed;
v.) Evaluator's name, signature, and credentials;
d) Any of the following diagnostic tools:
i.) Autism Diagnostic Observation Schedule/Autism Diagnostic Observation Schedule 2nd edition (ADOS/ADOS-2);
ii.) Childhood Autism Rating Scale/ Childhood Autism Rating Scale 2nd edition (CARS/CARS-2);
iii.) Gilliam Autism Rating Scale (GARS-3);
iv.) Fetal Alcohol Spectrum Disorders (FASD) Diagnostic Category;
v.) Other evidence-based assessments, reviewed on a case-by-case basis, include any of the following:
1) Screening Tool for Autism in Toddlers & Young Children (STAT);
2) Autism Diagnostic Interview Revised (ADI-R);
3) EarliPoint;
4) Rapid Interactive Screening Test for Autism in Toddlers (RITA-T);
5) Communication and Symbolic Behavior Scales Developmental Profile – Infant/Toddler Checklist (CSBS DP-ITC);
6) Modified Checklist for Autism in Toddlers/Modified Checklist for Autism in Toddlers, Revised with follow-up (M-CHAT/M-CHAT-R/F);
7) Social Communication Questionnaire (SCQ);
8) Autism Spectrum Screening Questionnaire (ASSQ);
9) Childhood Autism Spectrum Test, formerly known as the Childhood Asperger's Syndrome Test (CAST);
10) Social Responsiveness Scale, 2nd Ed. (SRS-2) Parent Report;

11) The Survey of Well-Being of Young Children (SWYC): Parent's Observations of Social Interactions (POSI);

e) Physical health concerns have been evaluated and ruled out as causal reasons for behavior (i.e., medical concerns, speech deficits, hearing deficits, heavy metal poisoning);

d. *Functional Behavior Assessment (FBA)*, includes all the following:
   i. Completed by a Board-Certified Behavior Analyst (BCBA), or other duly certified, licensed, or registered equivalent provider;
   ii. Record review;
   iii. Interviews;
   iv. Standardized rating scales;
   v. Direct observation and measurement of behavior using one of the following procedures:
      a) Continuous (records every occurrence and/or duration of a target behavior during each of a series of designated observation periods);
      b) Discontinuous procedures (divides each designated observation period into a series of brief intervals);
   vi. Results from at least one of the following types of assessments (to include visual representations [graphs, tables, grids] as appropriate), depending on the member/enrollee's noted areas of need:
      a) Maladaptive behavior assessments for members/enrollees who exhibit problem behaviors that are disruptive and/or dangerous, including but not limited to, one of following functional behavior assessments (FBA):
         i) Descriptive FBA (rating scales, direct observation, data review);
         ii) Traditional functional analyses;
         iii) Interview-Informed, Synthesized Contingency Analysis (IISCA);
      b) Skills acquisition assessments, for members/enrollees who demonstrate the need for skill acquisition, including but not limited to one of the following:
         i) Verbal Behavior Milestones and Assessment Placement Program (VB-MAPP);
         ii) Assessment of Basic Language and Learning Skills-Revised (ABLLSR);
         iii) Assessment of Functional Living Skills (AFLS);
         iv) Promoting the Emergence of Advanced Knowledge Generalization (PEAK) Skills Assessment;
         v) Essentials for Living (EFL);
         vi) Social Skills Improvement System (SSIS);
         vii) Socially Savvy;
         viii) Other valid forms of comprehensive evidence-based skills assessment tools;
         ***Note**: If the Vineland Adaptive Behavior Scales is used as a skills assessment, an additional, direct skills assessment is required from the list above.*

e. *Individualized treatment plan* aligns with the results of the FBA and/or skills assessment and includes all the following:
   i. Developed and approved by a licensed psychologist, BCBA-D or BCBA, supported by a BCaBA, where applicable;
   ii. A brief background and medical history;
   iii. Explicit parent/caregiver concerns;
   iv. Individualized goals with measurable, targeted outcomes, and timelines, including transition/discharge planning, including all the following:
      a) Identified in collaboration with the member/enrollee, family members, and community providers;
      b) Skill acquisition goals including baseline data and mastery criteria;
      c) Behavior reduction goals including baseline data, operational definition/topography of behavior, treatment strategies and graphs;
      d) Interventions focused on active core symptoms and emphasizing generalization and maintenance of skills in areas of need, including interventions related to development of spontaneous social communication, adaptive skills, and appropriate behaviors;
   v. A dedicated crisis plan, when clinically indicated;
   vi. When ABA services are coordinated with educational services, school-based documentation includes the following, as applicable:
   ***Note**: If an Individualized Education Plan (IEP), Plan of Care (POC) or 504 Accommodation Plan, identifies the need for ABA services, supporting documentation and coordination of services must be submitted with the request.*
      a) Documentation of school-based ABA treatment hours, when applicable;
      b) Target behaviors that are operationally defined with measurable data regarding the frequency, symptom intensity, duration, or other objective measures of baseline and current levels;
      c) Days and times when problem behaviors occur at a high frequency, intensity, and/or duration;
      d) Outline of goals related to behavior reduction and skill acquisition that represent desirable behaviors and achieve the same outcome or meet the same need as a less desirable problem behavior;
      e) Titration plan outlines when school services can be reduced or stopped, based on a timeline with clear progress criteria;
      f) Behavior reduction graphs tailored for the school setting, when applicable;
      ***Note**: The most recent school-based educational support plan may be shared as supporting documentation for members/enrollees who attend school.*
   vii. Treatment setting with rationale for how the setting will maximize treatment outcomes, considering the assessed needs, strengths, and available resources;
   viii. Number of treatment hours meets all the following:
      a) Justified by level of impairment, severity of symptoms, domains requiring treatment, length of treatment history, and response to intervention;

b) Considers member/enrollee's age, school attendance requirements, when applicable, and other daily activities (i.e., less than 20 hours per week if attending school full-time);
c) Incorporates supervision and caregiver training;
d) Outlines hours of therapy per day with the goal of increasing or decreasing the intensity of therapy as the member/enrollee's ability to tolerate and participate permits and all of the following:
    i) Treatment takes into consideration the developmental level of each member/enrollee, and treatment schedules support their needs, including rest and nutrition breaks, time in other therapies, as well as opportunities for peer interaction;
    Note: *If clinical documentation justifies that services at a lower intensity, frequency, or duration than requested are sufficient to reasonably achieve treatment goals, the health plan may authorize services at a lower intensity, frequency, or duration than requested.*
    ii) Treatment hours provided for the member/enrollee meet one of the following:
        1) Do not exceed six hours per day up to a total of 30 hours per week;
        2) Clinical documentation justifies additional hours beyond six hours per day or a total of 30 hours per week, including all of the following:
            a) Clinical observations and assessment findings indicate that the member/enrollee's current clinical needs cannot be adequately or effectively addressed at less than 30 hours per week and/or less than six hours per day due to the severity, frequency, and complexity of impairments that occur across different settings, including but not limited to any the following:
                i.) Persistent, frequent, and/or severe challenging behaviors, for example: self-injury, tantrums, elopement, etc.;
                ii.) Escalating problem behaviors, with data demonstrating an upward trend in frequency or severity despite the current level of ABA services delivered;
                iii.) Severe stereotypic behaviors that interfere with learning, including repetitive motor or vocal behaviors (e.g., hand flapping, vocal scripting) that significantly interfere with engagement in academic, adaptive, or therapeutic tasks;
                iv.) Limited functional communication, including nonverbal or minimal verbal presentation with reliance on maladaptive behaviors (e.g., screaming, grabbing) to communicate needs;
            b) A clinical rationale explaining how the requested additional ABA service hours will be utilized to directly target the identified goals and objectives requiring more intensive intervention, including but not limited to any of the following:

i.) Increased instructional trials to support skill acquisition and generalization;
ii.) More frequent or sustained practice opportunities to strengthen emerging skills;
iii.) Enhanced behavior reduction interventions for behaviors that continue to interfere with learning or daily functioning;

c) As applicable, active coordination of care, by multidisciplinary input, that the requested additional ABA treatment hours are clinically necessary, appropriate, not related to another medical need, and consistent with the member/enrollee's current overall treatment needs;
d) Signatures from the parent or legal guardian and the direct-care BCBA on the revised treatment plan;

ix. ABA services are delivered individually or in a group (two to eight participants), in a natural setting (e.g., home, school, community-based setting, or clinic), and are provided or supervised by an ABA-credentialed professional using evidence-based ABA techniques;
x. Adaptive Behavior Treatment with Protocol Modification occurs for at least two hours per week or 10% of the direct service hours provided, (whichever is greater and no more than 20% of direct service hours provided (unless clinical documentation justifies);
***Note**: One to two hours per week for less than 10 hours per week is acceptable.*
xi. Coordination of care includes all of the following, as applicable:
a) Identifies each alternative provider who is responsible for delivering services;
b) Documentation of dates and outcomes from coordination of care efforts;
c) Parent/guardian's documented consent;
xii. Parent/Caregiver training that is performance based and caregiver-driven, including all the following:
***Note**: Parent/guardian or designated authorized representative is responsible for being physically present and observant during intervention process occurring in the home.*
a) Two to four parent/caregiver training goals within the treatment plan including baseline data, expected behavior, and mastery criteria that identify their involvement in prioritizing target behaviors and training in behavioral techniques;
b) A documented plan for parent/caregiver training, generally for a minimum of two hours per month, with clinical documentation justifying the need for fewer hours;
c) An assessment for barriers to family engagement, and documented plan for addressing barriers;
Note: If member/enrollee and caregivers are unwilling/unable to implement therapeutic interventions, consideration will be given to other

modalities of treatment as ABA needs to be consistently applied in all environments to be successful.

xiii. Transition planning begins at treatment initiation and is updated throughout treatment, includes discharge considerations made with input from the caregiver and entire care team, involving a gradual step-down in services and a documented titration plan including all the following:
   a) Specific titration goals and plan indicating how service hours will be titrated;
   b) Individualized, realistic/attainable, and specific goals for discharge and/or transfer to alternative or less intensive levels of care;
   c) Recommended post-discharge services, when appropriate for the member/enrollee and a documented plan outlining how those services will be accessed;

4. *Continuation* of ABA treatment request includes all the following:
   a. Request is submitted 5 to 15 days prior to the last authorized date;
   b. Member/enrollee's behavior concerns are not exacerbated by treatment;
   c. Member/enrollee has the cognitive ability to retain and generalize advancement in treatment goals;
   d. There is reasonable expectation that the member/enrollee will benefit from the continuation of ABA services;
   e. Documentation of percentage of scheduled sessions successfully completed for the member/enrollee and caregiver participation;
      ***Note**: If attendance falls below 80% of the authorized hours within an authorization period, as specified in the individualized treatment plan and caregiver training plan, supporting documentation is required to justify continuation of ABA services at the previously approved level. When absences are attributed to medical, educational, or family barriers, documentation must also demonstrate the actions taken to address such barriers.*
   f. Parent/Caregiver training that is performance-based and caregiver-driven, including all the following:
      i. Two to four parent/caregiver training goals within the treatment plan including baseline data, expected behavior, and mastery criteria that identify their involvement in prioritizing target behaviors and training in behavioral techniques;
      ii. Documented family participation in treatment, ideally for two hours per month at minimum, or there are documented attempts to engage caregivers, unless clinical documentation supports the need for fewer hours;
      iii. An assessment of barriers to family engagement, and documented plan for addressing barriers;
         ***Note**: If member/enrollee and caregivers are unwilling/unable to implement therapeutic interventions, consideration will be given to other modalities of treatment as ABA needs to be consistently applied in all environments to be successful.*
   g. Documented coordination of care and communication regarding additional

provider responsibilities, when applicable (i.e., school, prescribers, and physical, occupational and/or speech therapists) and including all the following:
   i. Individualized expectations, prescribed services, service frequency, scope and duration, and goals to be achieved;
   ii. Progress related to treatment/services provided;
   iii. Documentation of coordination attempts if unsuccessful;

h. Updated treatment plan completed at least every six months (or as clinically appropriate) and meets criteria I.D.3.e. and transition planning meets all the following:
   i. Transition planning and discharge considerations made with input from the entire care team and involving a gradual step-down in services;
   ii. Documented titration plan includes the following:
      a) Specific titration goals and plan indicating how service hours will be titrated;
      b) Individualized, realistic/attainable, and specific goals for discharge and/or transfer to alternative or less intensive levels of care;
      c) Updated progress towards goals achieved over the prior authorization period;
      d) Recommended services member/enrollee can access upon discharge;

i. Documented progress toward goals since the last authorization including all the following:
   i. Updated data collected during previous treatment authorization, corresponding to all applicable treatment settings, including but not limited to, home, school, clinic, community setting, etc.;
   ii. Progress with behavior reduction, as applicable, noted in a clear and legible graphic display, including all the following:
      a) Clear labels on each axis with indicators of treatment changes and environmental variables that could affect change;
      b) Baseline data;
      c) Behavior reduction progress over time;
      d) Frequency and/or duration of behaviors;
   iii. Progress with skill acquisition goals including baseline data and updated progress data for each treatment goal;

j. If limited progress, both of the following:
   Note: Limited progress is defined as minimal to no improvement toward: mastery of treatment goals, improvement in meaningful skills of independence and self-care, improved scores on direct skills assessments and/or minimal reduction in behaviors targeted for reduction.
   i. Updated assessment identifies determining factors that may be contributing to inadequate progress;
   ii. Changes to the treatment plan from the prior authorization period may include the following, as applicable:
      a) Modification of treatment plan goals and intervention strategies;

b) Increased time and/or frequency working on targets;
c) Increased parent/caregiver training and supervision;
d) Increased staff supervision and training;
e) Identification and resolution of barriers to treatment implementation;
f) Newly identified co-existing conditions, as applicable;
g) Consideration of alternative treatment settings;
h) Consideration of the effectiveness of ABA;
i) Evaluation for other services that may be helpful for added support including but not limited to, speech therapy, occupational therapy, psychiatric evaluation, psychotherapy, case management, family therapy, feeding therapy, and school-based supports.

II. It is the policy of Silver Summit health plan that when a covered benefit, Applied Behavior Analysis (ABA) services may be appropriate for **discontinuation and/or transfer to alternative or less intensive levels of care** when meeting any of the following:

A. Member/enrollee has achieved the desired, socially significant outcomes and treatment is not required to maintain functioning or prevent regression;
B. Services are in lieu of school, respite care, or other community-based settings of care;
C. There has been no clinically significant progress or measurable improvement towards treatment plan goals for a period of at least six months, despite documented treatment modifications, and there is not a reasonable expectation that a revised treatment plan could lead to clinically significant progress, such as, but not limited to, the following:
    1. A consistent lack of change in behavior reduction and skill acquisition data;
    2. An increase in behaviors targeted for reduction;
    3. Failure to meet predefined mastery criteria for a specified duration;
    4. ABA treatment plan gains are not generalizable or durable over time and do not transfer to the larger community setting after successive progress review periods and repeated modifications to the treatment plan;
D. Treatment or intensity of treatment is being provided for the convenience or preference of the member/enrollee, parent/guardian, or other non-ABA service providers (school or other alternative providers);
E. The family or the behavior analyst makes the decision to end or temporarily suspend services due to, but not limited to, any of the following:
    1. The parent/caregiver can continue the behavior interventions independently;
    2. The parent/caregiver wants to discontinue services and withdraws consent for treatment;
    3. The parent/caregiver and provider are unable to reconcile essential issues in treatment planning and delivery;
    4. The parent/caregiver's circumstances or interest in treatment change;
F. The member/enrollee has transitioned to another provider or community resources for alternative treatment.

III. It is the policy of Silver Summit health plan that Applied Behavior Analysis (ABA) services are **non-covered** for any of the following:

A. Services that do not meet Nevada Medicaid medical necessity requirements;
B. Services used to reimburse a parent/guardian for participation in the treatment plan;
C. Services rendered by the parent/guardian;
D. Treatment whose purpose is vocationally or recreationally based;
E. Services, supplies, or procedures performed in a non-conventional setting including, but not limited to, resorts, spas and camps;
F. Custodial service, including all of the following:
    1. Care provided primarily to assist with activities of daily living (ADLs) such as bathing, dressing, eating, and safety;
    2. Services provided primarily for the purpose of maintaining the safety of the member/enrollee or others;
    3. Services provided by individuals who do not possess professional skills or required training;
G. Services not authorized by the QIO-like vendor if an authorization is required according to policy;
H. Respite services;
I. Child-care services;
J. Services for education;
K. Equine therapy;
L. Hippotherapy;
M. Phone consultation services;
N. Care coordination and treatment planning billed independently of direct service;
O. Services that are otherwise covered under the Individuals with Disabilities Education Act (IDEA);
    ***Note**: Unless restricted within a state Medicaid benefit, ABA services can occur in coordination with school services and transition plans.*
P. ABA services cannot be reimbursed on the same day as Basic Skills Training (BST) and Psychosocial Rehabilitation (PSR);
Q. Treatment goals more appropriately conducted in any of the following disciplines:
    1. Behavioral health outpatient services;
    2. Speech therapy;
    3. Occupational therapy;
    4. Vocational rehabilitation;
    5. Supportive respite care;
    6. Recreational therapy;
    7. Physical therapy.

Background

Applied Behavior Analysis (ABA) is the design, implementation and evaluation of environmental modifications using behavior stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. ABA

is a behavior intervention model based on reliable evidence-based practices focusing on targeted skills in all areas of development.[1]

There are two types of ABA treatment delivery models recognized by the DHCFP, Focused and Comprehensive. Focused ABA refers to treatment, provided directly to the patient, to improve or maintain behaviors in a limited number of domains or skill areas. Access to focused intervention should not be restricted by age, cognitive level, diagnosis, or co-occurring conditions. Comprehensive ABA refers to treatment provided directly to the patient to improve or maintain behaviors in many skill areas across multiple domains (e.g., cognitive, communicative, social, behavioral, adaptive).[1,3]

The EPSDT benefit plan encourages providers to follow the recommended schedule for screenings offered by the AAP for individuals under age 21. The behavior intervention must be medically necessary (reference MSM Chapter 100) to develop, maintain, or restore to the maximum extent practical the functions of an individual with a diagnosis of ASD, FASD or other condition for which ABA is recognized as medically necessary. [4]

In 2025, the National Academies of Sciences, Engineering, and Medicine conducted a comprehensive autism care demonstration report for military families. The report concluded that the intensity of ABA services should be individualized, based on the needs of the person with autism, the priorities of their family, and the expertise of the professional's providing services.

The committee did not endorse a uniform recommendation that all individuals with autism receive the same intensity (e.g., 30-40 hours per week). Instead, the number of weekly hours of direct ABA services required to support meaningful health outcomes should be determined by a qualified behavior analyst, taking into consideration the following:
1. The number and type of goals targeted in treatment.
2. Other services the client receives.
3. The client's learning rate.
4. Input from the client and their family.

Council of Autism Service providers (CASP)[3]
The Council of Autism Service Providers (CASP) has developed guidelines and recommendations that reflect established research findings and best clinical practices. There are five core characteristics of applied behavior analysis (ABA) that should be present throughout all phases of assessment and treatment in the form of essential practice elements as follows:
<u>Core characteristics of ABA treatment:</u>
1. An objective assessment and analysis of the person's condition by observing how the environment affects their behavior, as evidenced through appropriate measurement.
2. Understanding the context of the behavior and the behavior's value to the person, their caregivers, their family, and the community.
3. Promotion of the person's dignity
4. Utilization of the principles and procedures of behavior analysis to improve the person's health, skills, independence, quality of life and autonomy.
5. Consistent, ongoing, objective data analysis to inform clinical decision making.

Essential practice elements:

1. A comprehensive assessment that describes specific levels of behavior(s) at baseline and informs the subsequent establishment of meaningful treatment goals.
2. An emphasis on understanding the current and future value or social importance of behavior(s) targeted for treatment.
3. Reasonable efforts toward collaboration with the person receiving treatment, their guardians if applicable, and those who support them (e.g., caregivers, care team) in developing meaningful treatment goals.
4. A practical focus on establishing small units of behavior that build toward larger, more significant changes in abilities related to improved health, safety, skill acquisition, and/or levels of independence and autonomy.
5. Collection, quantification, and analysis of direct observational data on behavioral targets during treatment and follow-up to maximize and maintain progress toward treatment goals.
6. Design and management of social and learning environment(s) to minimize challenging behavior(s) and maximize the rate of progress toward all goals.
7. An approach to the treatment of challenging behavior that links the function(s) of, or the reason(s) for, the behavior with programmed intervention strategies.
8. Use of a carefully constructed, individualized, and detailed behavior-analytic treatment plan that utilizes reinforcement and other behavioral principles and excludes methods or techniques not based on established behavioral principles and theory.
9. Use of treatment protocols that are implemented repeatedly, frequently, and consistently across environments until discharge criteria are met.
10. An emphasis on frequent, ongoing analysis and adjustments to the treatment plan based on patient progress.
11. Direct training of caregivers and other involved laypersons and professionals, as appropriate, to support increased abilities and generalization and maintenance of behavioral improvements.
12. A comprehensive infrastructure for case supervision by a behavior analyst of all assessments and treatment.

Council of Autism Service Providers (CASP) Practice Parameters for Telehealth-Implementation of Applied Behavior Analysis[5]

Due to a shortage of providers and disparities which exist in behavioral health care access, telehealth services have become a viable solution to address health access to treat members/enrollees with ASD. This service is not intended to replace in person service, as it is intended to supplement the traditional in person service delivery model.[4]" Clinical decisions on telehealth service delivery models should be selected based on the individual needs, strengths, preference of service modality, caregiver availability, and environmental support available. Providers should refer to respective state allowances for telehealth services and reference the most updated CASP Practice Parameters for Telehealth-Implementation of Applied Behavior Analysis.

American Academy of Pediatrics (AAP)[6]

The AAP recommends that all children be screened for ASD at ages 18 and 24 months, along with regular developmental surveillance. Toddlers and children should be referred for diagnostic evaluation when increased risk for developmental disorders (including ASD) is identified through screening and/or surveillance. Although symptoms of ASD are neurologically based, they manifest behavioral characteristics that present differently depending on age, language level, and cognitive abilities. Core symptoms cluster in 2 domains (social communication, interaction, and restricted, repetitive patterns of behavior), as described in the DSM-5TR.

The Diagnostic and Statistical Manual of Mental Disorder, Fifth edition (DSM-5-TR)[7]

The Diagnostic and Statistical Manual of Mental Disorder lists the following as the severity levels for autism spectrum disorders. They are divided into two domains (social communication and social interaction and restrictive, repetitive patterns of behaviors) To fulfill diagnostic criteria for ASD by using the DSM-5- TR, all 3 symptoms of social affective difference need to be present in addition to 2 of 4 symptoms related to restrictive and repetitive behaviors.

Severity Level	Social Communication	Restricted, repetitive behaviors
Level 3 "Requiring very substantial support"	Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and when he/she does, makes unusual approaches to meet needs only and responds to only very direct social approaches.	Inflexibility of behavior, extreme difficulty coping with change or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changes focus or action.
Level 2 "Requiring substantial support"	Marked deficits in verbal and nonverbal communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interest, and who has markedly odd nonverbal communication.	Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer in a variety of context. Distress and/or difficulty changing focus or action.
Level 1 "Requiring support"	Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions. For example, a person who can speak in full sentences and engages in communication but who is to and from conversation with others fails, and who attempts to make friends are odd and typically unsuccessful.	Inflexibility of behavior cases significant interference with functioning in one or more context. Difficulty switching between activities. Problems of organization and planning hamper independence.

Coding Implications

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from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance and applicable state guidance, prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
97151	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/ interpreting the assessment, and preparing the report/treatment plan
97152	Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes
0362T	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior
0373T	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits.

CPT®* Codes	Description
	destructive behavior; completion in an environment that is customized to the patient's behavior

Reviews, Revisions, and Approvals	Revision Date	Approval Date
New Policy	07/26	

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed

herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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