



## Applied Behavior Analysis for the Treatment of Autism

### Original Effective

**Date:** December 2016

**Reviewed:** December 2020

**Revised:** May 2020

*This policy applies to all products unless specific contract limitations, exclusions or exceptions apply. Please refer to the member's benefit certificate language for benefit availability. Managed care guidelines related to referral authorization, precertification of inpatient hospitalization, home health, home infusion and hospice services apply.*

### Description

**Applicability:** Federal Employee Program (FEP)

**Note:** The member's benefit plan determines coverage, applied behavior analysis (ABA) therapy for all other indications except for the treatment of autism will be considered a **non-covered benefit**.

**Providers will need to complete the following form for all prior approval requests:**

### The Prior Approval Form

- The [prior approval form](#) is to be completed and submitted for all prior approval requests for ABA therapy services to include the treatment assessment request, initial treatment request and continuation of treatment requests.

### Autism Spectrum Disorder

The diagnosis of autism spectrum disorder (ASD) has been validated by a documented comprehensive assessment demonstrating the presence of the following diagnostic criteria for autism spectrum disorder (ASD) based on The Diagnostic and Statistical Manual of Mental Disorders (DSM-5):

- A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive):
  1. Deficits in social-emotional reciprocity, ranging, for example from abnormal social approach and failure of normal back-and-forth conversation; to reduce

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

**Specify Current Severity:** Severity is based on social communication impairments and restricted, repetitive patterns of behavior. (See below)

- B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by a least two of the following, currently or by history (examples are illustrative, not exhaustive):
  1. Stereotyped or repetitive motor movements, use of objects or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
  2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
  3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
  4. Hyper or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

**Specify current severity:** Severity is based on social communication impairments and restricted, repetitive patterns of behavior. (See below)

- C. Symptoms must be present in the early development period (but may not become fully manifested until social demands exceed limited capacities, or may be masked by learned strategies in later life).
- D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning
- E. These disturbances are not better explained by intellectual disability (intellectual development disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

## Severity Levels for Autism Spectrum Disorder

Severity Level	Social Communication	Restricted, Repetitive Behaviors
<b>Level 3 – Requiring very substantial support</b>	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 or 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 in changing focus or action.
<b>Level 2 – Requiring substantial support</b>	Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, 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 and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.
<b>Level 1 – Requiring support</b>	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 is able to speak in full sentences and engages in communication but whose to-and-fro conversation with others fails, and whose attempts to make friends are odd and typically unsuccessful.	Inflexibility of behavior causes significant interference with functioning in or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

## **Applied Behavior Analysis (ABA)**

Applied behavior analysis (ABA) focuses on the analysis, design, implementation, and evaluation of social and other environmental modifications to produce meaningful changes in human behavior. ABA includes the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. ABA uses changes in environmental events, including antecedent stimuli and consequences, to produce practical and significant changes in behavior. These relevant environmental events are usually identified through a variety of specialized assessment methods. ABA is based on the fact that an individual's behavior is determined by past and current environmental events in conjunction with organic variables such as their genetic endowment and physiological variables. Therefore, when applied to autism spectrum disorder (ASD), ABA focuses on treating the problems of the disorder by altering the individual's social and learning environments.

### **Essential Practice Elements of ABA**

- Comprehensive assessment that describes specific levels of behavior at baseline and informs subsequent establishment of treatment goals.
- An emphasis on understanding the current and future value (or social importance) of behavior(s) targeted for treatment.
- A practical focus on establishing small units of behavior which build towards larger, more significant changes in functioning related improved health and levels of independence.
- Collection, quantification, and analysis of direct observational data on behavioral targets during treatment and follow-up to maximize and maintain progress toward treatment goals.
- Efforts to design, establish, and manage the social and learning environment(s) to minimize problem behavior(s) and maximize rate of progress toward all goals.
- An approach to the treatment of problem behavior that links the function of (or the reason for) the behavior to the programmed intervention strategies.
- Use of carefully constructed, individualized and detailed behavior-analytic treatment plan that utilizes enforcement and other behavioral principles and excludes the use of methods or techniques that lack consensus about their effectiveness based on evidence in peer-reviewed publications.
- Use of treatment protocols that are implemented repeatedly, frequently, and consistently across environments until discharge criteria are met.
- An emphasis on ongoing and frequent direct assessment, analysis, and adjustments to the treatment plan based on client progress as determined by observations and objective data analysis.
- Direct support and training of family members and other involved professionals to promote optimal functioning and promotes generalization and maintenance of behavioral improvements.
- A comprehensive infrastructure for supervision of all assessment and treatment by a Behavior Analyst.

## Treatment Models

ABA treatment programs for autism spectrum disorder (ASD) incorporate findings from hundreds of applied studies focused on understanding and treating ASD published in peer reviewed journals over a 50-year span. Treatment may vary in terms of intensity and duration, the complexity and range of treatment goals, and the extent of direct treatment provided. Many variables, including the number, complexity, and intensity of behavioral targets and the individuals own response to treatment help determine which model is most appropriate. Although existing on a continuum, these differences can be generally categorized as one of the two treatment models: Focused or Comprehensive ABA Treatment.

- **Focused ABA Treatment:** Refers to treatment provided directly to the individual for a limited number of behavioral targets. It is not restricted by age, cognitive level, or co-occurring conditions. Focused ABA treatment may involve increasing socially appropriate behavior (for example, increasing social initiations) or reducing problem behavior (for example, aggression) as the primary target. Even when reduction of problem behavior is the primary goal, it is critical to also target increases in appropriate alternative behavior, because the absence of appropriate behavior is often the precursor to serious behavior disorders.
  - Focused ABA plans are appropriate for individuals who (a) need treatment only for a limited number of key functional skills or (b) have such acute problem behavior that its treatment should be the priority.
    - Examples of key functional skills include, but are not limited to, establishing instruction-following, social communication skills, compliance with medical and dental procedures, sleep hygiene, self-care skills, safety skills, and independent leisure skills (for example, appropriate participation in family and community activities).
    - Examples of severe problem behaviors requiring focused intervention include, but are not limited to, self-injury, aggression, threats, pica, elopement, feeding disorders, stereotypic motor or vocal behavior, property destruction, noncompliance and disruptive behavior, or dysfunctional social behavior.
- **Comprehensive ABA Treatment:** Refers to treatment of the multiple affected developmental domains, such as cognitive, communicative, social, emotional, and adaptive functioning. Although there are different types of comprehensive treatment, one example is early intensive behavioral intervention where the overarching goal is to close the gap between the individual's level of functioning and that of typically developing peers. Comprehensive treatment may also be appropriate for older individuals diagnosed with ASD, particularly if they engage in severe or dangerous behaviors across environments.
  - Initially, treatment is typically provided in structured therapy sessions, which are integrated with more naturalistic methods as appropriate. As the individual progresses and meets established criteria for participation in larger or different settings, treatment in those settings and in the larger community should be provided.

- Training family members and other caregivers to manage problem behavior and to interact with the individual with ASD in a therapeutic manner is a critical component of this treatment model.

## Goals of ABA Therapy

### Overall goal of treatment is to:

- Maximize functioning
- Move the individual toward independence
- Improve the quality of life for the individual and family

### Specific goals are to:

- Improve social functioning
- Improve communication skills (both functional and spontaneous)
- Improve adaptive skills
- Decrease nonfunctional or negative behaviors
- Promote academic functioning and cognition

## Coordination with Other Professionals

Applied behavior analysis (ABA) therapy is typically provided by a treatment team rather than individual provider.

Consultation with other professionals helps ensure client progress through efforts to coordinate care and ensure consistency including during transition periods and discharge.

Treatment goals are most likely achieved when there is a shared understanding and coordination among all healthcare providers and professionals. Examples include collaboration between the prescribing physician and the Behavior Analyst to determine the effects of medication on treatment targets. Another example involves a consistent approach across professionals from different disciplines in how behaviors are managed across environments and setting. Professional collaboration that leads to consistency will produce the best outcomes for the client and their families.

The multidisciplinary team for ABA therapy may consist of the following:

- **Board Certified Behavior Analysts:** Conduct behavioral assessments and provide interpretations of the results of such assessments. They design and supervise behavior analytic interventions to address both the acquisition of skills and the reduction of challenging behaviors. Many board-certified behavior analysts also hold licenses or certifications in other disciplines (e.g. psychology).
- **Counseling/Psychological Service Providers:** These individuals may include clinical psychologists, counseling psychologists, marriage and family counselors, social workers, psychiatric nurses or related professionals. They may provide parent training or support, social skills groups, clinical behavior therapy, play therapy. In some cases, the involvement of these providers may be restricted to conducting evaluations and making recommendations.

- **Developmental Pediatrician or Pediatrician with Advanced Training in Focused Developmental Evaluations:** These individuals possess training and experience to assess and treat the medical and psychological aspects of children and adolescents developmental and behavioral problems.
- **Pediatric Neurologist:** These individuals diagnose and treat a variety of conditions in children such as seizures, head injuries or muscle weakness. They also develop plans and help manage the care of children that have disorders such as attention deficit hyperactivity disorder (ADHD) and autism.
- **Child and Adolescent Psychiatrists:** Is a physician who specializes in the diagnosis and treatment of disorders of thinking, feeling and/or behavior affecting children, adolescents and their families. A comprehensive diagnostic examination is performed to evaluate the current problem with attention to its physical, genetic, developmental, emotional, cognitive, educational, family, peer and social components. Once a diagnosis is established, the child and adolescent psychiatrist designs a treatment plan which may involve an integrated approach to include individual, group or family psychotherapy; medication; and/or consultation with other physicians or professionals from schools, juvenile courts, social agencies or other community organizations. In addition, the child and adolescent psychiatrist is prepared and expected to act as an advocate for the best interest of the child and the adolescent.
- **Early Intervention Providers:** Early intervention providers seek to address the needs of children suspected of disabilities from birth to three years of age. In some states, early intervention is defined as birth to five years of age. As is the case with special education services, children in this age group must meet eligibility criteria in order to qualify for services. Priorities in early intervention often include addressing deficits in cognitive, language, motor, social, play and self-care skills, reducing the gap between the child's skills and those of his/her typically developing age mates, and preparing the child for public school. Early intervention providers deliver an array of services to both the child and the family and these should be clearly identified on a child's Individualized Family Services Plan (IFSP).
- **General Education Teachers:** General education teachers work with students in preschool, elementary and secondary schools. They provide services to large groups of students although class sizes range from school to school. Given the federal mandate that children participate to the fullest extent possible in least restrictive settings, children with autism and related disorders have considerable contact with general education teachers. This may involve an all-day placement or parts of the day (selected carefully by the team). A child with autism may participate in general education classroom or classrooms with or without the support of a paraprofessional.
- **Special Education Teachers:** In contrast to general education teachers, special education teachers focus upon meeting the unique educational needs of children with identified disabilities such as autism. They provide an array of services which should be clearly identified on a student's Individualized Education Plan (IEP). Many special education teachers either work with students with autism in self-contained classrooms or in resource rooms with the distinction related to the amount of time the child spends with the special education teacher. In addition, the special education teacher typically supervises the efforts of paraprofessionals. When a student is determined to be eligible for special education services, the special education teacher often assumes a case

management role to help coordinate the services of various providers on the multidisciplinary team.

- **Paraprofessionals:** The goal of paraprofessional teaching staff is to support the efforts of the teachers. Their involvement varies widely with respect to both the amount and nature of contact. For example, paraprofessionals may be involved in one to one teaching, small group instruction, and shadowing and supporting the child with autism in a general education classroom. Given the role they serve and the amount of direct contact that they have with their students, it is imperative that they receive the training, mentorship, and supervision necessary to maximize their skills and competencies.
- **Occupational Therapists (OT):** Occupational therapists provide training in daily living skills such as dressing and hygiene, as well as fine motor skills related to holding objects, handwriting, cutting and other activities. Their treatments rely on the use of specific tasks or goal-directed activities designed to improve the functional performance of an individual as it relates to the smaller muscle groups. They may also work on sitting, posture, and perceptual skills (i.e. recognizing differences in color, shape and size) and many occupational therapists specialize in feeding and swallowing.
- **Physical Therapists (PT):** As is the case with occupational therapists, physical therapists are also concerned with improving or restoring physical function; however, they focus upon the larger muscle groups. They also use therapeutic exercises to reduce pain or improve posture, locomotion, strength, endurance, balance, coordination, joint mobility and range of movement and flexibility. Exercises may be active or passive (i.e. performed by the individual or performed on the individual by the therapist or by specialized equipment) and are based upon biomechanical and neurophysiologic principles. Physical therapy does not include adaptive physical education or dance therapy.
- **Speech and Language Pathologists (SLPs):** Speech and language pathologists are involved in the treatment of communication and speech impairments. Treatment areas may include muscle control related to speech production, articulation, prosody, vocabulary development, receptive and expressive language skills, conversation skills, and social pragmatics.

Suggested testing by the multidisciplinary team normally includes the following:

- Autism specific testing (ADOS, ADI-R CARS, etc.)
- Hearing evaluation
- Speech/language/communication assessment (Peabody Picture Vocabulary test )PPVT), Expressive Vocabulary Test (EVT), etc
- Developmental/cognitive testing (IQ, for instance Bayley Scales of Infant Development, WECHSLER PRESCHOOL AND PRIMARY SCALE OF INTELLIGENCE, etc)
- Adaptive behavioral evaluation (VABS, ABAS)
- Sensorimotor evaluation
- Laboratory work as suggested by assessment

## The Assessment Process

A developmentally appropriate ABA assessment process must identify strengths and weaknesses across domains and potential barriers to progress. The information from this process is the basis of developing the individualized ABA treatment plan. An ABA assessment typically utilizes information obtained from multiple methods and multiple informants, including the following:

- **File Review:** information about medical status, prior assessment results, response to prior treatment and other relevant information may be obtained via file review and incorporated into the development of treatment goals and intervention. Examples of assessments that should be reviewed include intellectual and achievement tests, developmental assessments, assessments of comorbid mental health conditions, and evaluations of family functioning and needs. In some cases, if assessment information is incomplete, the provider/behavior analyst should refer the individual to other professionals for needed assessments.
- **Interviews and Rating Scales:** Patient, caregivers, and other stakeholders, as appropriate, are included when selecting treatment goals, developing protocols and evaluating progress. Behavior Analysts/providers use interviews, rating scales, and social validity measures to assess perceptions of the patient's skill deficits and behavioral excesses, and the extent to which these deficits and excesses impede the life of the individual and the family. Examples of rating scales include adaptive-behavior assessments, functional assessments, among others.
- **Direct Assessment and Observation:** Direct observation and data collection and analysis are defining characteristics of ABA. The analysis of such data serves as the primary basis for identifying pretreatment levels of functioning, developing and adapting treatment protocols on an ongoing basis, and evaluating response to treatment and progress toward goals. Behavior should be directly observed in a variety of relevant naturally occurring settings and structured interactions. Examples of structured direct assessments include curricular assessment, structured observations of social interactions, among others.
- **Assessment from Other Professionals:** Periodic assessments from other professionals may be helpful in guiding treatment or assessing progress. Examples might include assessment of general intellectual functioning, medical status, academic performance, among others.

The assessment process required for the initial development of comprehensive treatment programs may take 20 hours or longer. Subsequent assessments and assessments for focused treatments that involve a small number of uncomplicated goals often require fewer hours. The functional assessment for severe problem behavior is often complex and may require considerably longer durations.

Assessment of overall progress toward comprehensive treatment goals should be summarized at regular intervals.

## Selecting and Monitoring Progress Toward Treatment Goals

Goals are prioritized based on their implications for the individual's health and well-being, the impact on patient, family, and community safety, and contribution to functional independence. ABA treatment are identified based on the assessment process. Each goal should be defined in a specific, measurable way to allow frequent evaluation of progress toward a specific mastery criterion. The number and complexity of the goals should be consistent with the intensity and setting of service provision. The appropriateness of existing and new goals should be considered on a periodic basis.

The measurement system for tracking progress toward goals should be individualized to the client, the treatment context, the critical features of the behavior and the available resources of the treatment environment. Specific, observable and quantifiable measures should be collected for each goal and should be sensitive enough to capture meaningful change relative to ultimate treatment goals.

The results of standardized assessments may be used to monitor progress toward long-term treatment goals. However, IQ scores and other global assessments are not appropriate as sole determiners of an individual's response or nonresponse to ABA treatment. Many individuals may show substantial progress in important characteristics of the disorder (for example, language functioning, social functioning, repetitive behavior, adaptive behavior, safety and wellness, and co-morbid mental health conditions) without a substantial change in measures of intellectual functioning.

## Functional Assessment of Problem Behavior

When an individual exhibits problem behavior at a level that is disruptive to the environment or dangerous to themselves or others, a functional assessment is warranted. Functional assessment refers to the overall process of identifying the aspects of the environment that may contribute to the development and continued occurrence of problem behavior. A functional assessment is designed to identify where, when and the likely reasons why a problem behavior occurs. This information is then directly incorporated into the problem behavior treatment plan in the form of a function-based intervention.

- The functional assessment process typically includes multiple sources of information such as interviews with caregivers, structured rating scales, and collection of direct observation data and consideration of potential medical conditions that may impact problem behavior.
- Direct observation may take the form of assessment of ongoing interactions in the natural environment or the form of a functional analysis.
- Functional analysis refers to directly changing environmental events and evaluating the impact of those changes on the level of problem behavior via direct observation. Functional analyses can be complex and may require higher staffing ratios and more direction by the Behavior Analyst.

## Clinical Features of a Treatment Plan for ABA Therapy Services

The ABA treatment plan for ABA therapy Services should include the following information:

- Patient Information
- Reason for Referral
- Brief Background Information
  - Demographics (name, age, gender, diagnosis)
  - Living situation
  - Home/school/work information
- Clinical Interview
  - Information gathering on problem behaviors, including developing operational definitions of primary area of concern and information regarding possible function of behavior.
- Review of Recent Assessments/Reports (File Review)
  - Any recent functional behavior assessment, cognitive testing, and/or progress reports
- Assessment Procedures and Results
  - Brief description of assessments, including their purpose
    - INDIRECT ASSESSMENTS:
      - Provide summary of findings for each assessment (graphs, tables or grids)
    - DIRECT ASSESSMENTS
      - Provide summary of findings for each assessment (graphs, tables, or grids)
  - Target behaviors are operationally defined, including baseline levels
- Treatment Plan (Focused ABA)
  - Treatment setting
  - Operational definition for each behavior and goal
  - Specify behavior management (that is behavior reduction and/or acquisition) procedures:
    - Antecedent-based interventions
    - Consequence-based interventions
  - Describe data collection procedures
  - Proposed goals and objectives\*
- Treatment Plan (Skill Acquisition – Comprehensive ABA)
  - Treatment Setting
  - Instructional Methods to be Used
  - Operational Definition of each skill
  - Describe data collection procedures
  - Proposed goals and objectives\*
- Patient/Caregiver Training
  - Specify parent training procedures
  - Describe data collection procedures
  - Proposed goals and objectives\*

- Number of Hours Requested
  - Number of hours needed for each service
  - Clinical summary that justifies hours requested
  - Billing codes requested (CPT, HCPCS)
- Coordination of Care
- Transition Plan
- Discharge Plan
- Crisis Plan

\*Each goal and objective must include:

- Current level (baseline)
- Behavior individual is expected to demonstrate, including condition under which it must be demonstrated and mastery criteria (the objective or goal)
- Parent/caregiver training and expected results
- Date of introduction
- Estimated date of mastery
- Specify plan for generalization
- Report goal as met, not met, modified (include explanation)

### **Treatment Dosage for ABA Therapy**

Treatment dosage, which is often referenced in treatment literature as “intensity” will vary with each individual and should reflect the goals of treatment, specific patient needs, and response to treatment. Treatment dosage should be considered in two distinct categories: intensity and duration.

- **Intensity:** Is typically measured in terms of number of hours per week of direct treatment. Intensity often determines whether the treatment falls into the category of either focused or comprehensive:
  - Focused ABA treatment generally ranges from 10-25 hours per week of direct treatment (plus direct and indirect supervision and caregiver training). However, certain programs for severe destructive behavior may require more than 25 hours per week of direct therapy.
  - Comprehensive ABA treatment often involves an intensity level of 30-40 hours of 1:1 direct treatment to the individual per week, not including caregiver training, supervision, and other needed services. However, very young children may start with a few hours of therapy per day with the goal of increasing intensity of therapy as their ability to tolerate and participate permits. Treatment hours are subsequently increased or decreased based on the individual’s response to treatment and current needs. Hours may be increased to more efficiently reach treatment goals. Decreases in hours of therapy per week typically occur when an individual has met a majority of the treatment goals and is moving toward discharge.

Although the recommended number of hours of therapy may seem high, this is based on research findings regarding the intensity required to produce good outcomes.

- **Duration:** Treatment duration is effectively managed by evaluating the individuals' response to treatment:
  - This evaluation can be conducted prior to the conclusion of an authorization period. Some individuals will continue to demonstrate medical necessity and require continued treatment across multiple authorization periods.

### **Care Supervision Activities for ABA Therapy**

Care supervision activities can be described as those that involve contact with the client or caregivers (direct supervision, also known as clinical direction) and those that do not (indirect supervision). Both direct and indirect case supervision activities are critical to producing good treatment outcomes and should be included in service authorizations. It should be noted that direct case supervision occurs concurrently with the delivery of direct treatment to the individual. On average, direct supervision accounts for 50% or more of case supervision.

- **Direct Supervision Activities**
  - Directly observe treatment implementation for potential program revision
  - Monitor treatment integrity to ensure satisfactory implementation of treatment protocols
  - Directly staff and/or caregivers in the implementation of new or revised treatment protocols (individual present)
- **Indirect Supervision Activities**
  - Develop treatment goals, protocols, and data collection systems
  - Summarize and analyze data
  - Evaluate client progress toward treatment goals
  - Adjust treatment protocols based on data
  - Coordination for care with other professionals
  - Crisis intervention
  - Report progress towards treatment goals
  - Develop and oversee transition/discharge plan
  - Review the individuals progress with staff without the individual present to refine treatment protocols
  - Directing staff and/or caregivers in the implementation of new or revised treatment protocols (individual absent)

## **Dosage of Case Supervision for ABA Therapy**

Although the amount of supervision for each case must be responsive to the individual's needs, 2 hours for every 10 hours of direct treatment is the general standard of care. When direct treatment is 10 hours per week or less, a minimum of 2 hours per week of case supervision is generally required. Case supervision may need to be temporarily increased to meet the needs of the individual at specific times periods in treatment (for example, initial assessment, significant change in response to treatment).

This ratio of case supervision hours to direct treatment hours reflects the complexity of the individual's ASD symptoms and the responsive, individualized, data-based decision-making which characterizes ABA treatment. A number of factors increase or decrease case supervision needs on a shorter -or longer- term basis. These include:

- Treatment dosage/intensity
- Barriers to progress
- Issues of client health and safety (for example, certain skill deficits, dangerous problem behavior)
- The sophistication or complexity of treatment protocols
- Family dynamics or community environment
- Lack of progress or increased rate of progress
- Changes in treatment protocols
- Transitions with implications for continuity of care

## **Parent and Caregiver Training**

Training of parents and other caregivers usually involves a systematic, individualized curriculum on the basics of ABA. It is common for treatment plans to include several objective and measurable goals for parents and other caregivers. Training emphasizes skill development and support so that caregivers become competent in implementing treatment protocols across critical environments. Training usually involves an individualized behavioral assessment, case formulation, and then customized didactic presentations, modeling and demonstrations of the skill, and practice with vivo support for each specific skill. Ongoing activities involve supervision and coaching during implementation, problem-solving as issues arise, and support for implementation of strategies in new environments to ensure optimal gains and promote generalization and maintenance of therapeutic changes.

## **Discharge, Transition Planning, and Continuity of Care**

The desired outcomes for discharge should be specified at the initiation of services and refined throughout the treatment process. Transition and discharge planning from a treatment program should include a written plan that specifies details of monitoring and follow-up as is appropriate for the individual and the family. Parents, community caregivers, and other involved professionals should be consulted as the planning process accelerates with 3-6 months prior to the first change in service.

A description of roles and responsibilities of all providers and effective dates for behavioral targets that must be achieved prior to the next phase should be specified and coordinated with all providers, the individual, and family members.

Discharge and transition planning from all treatment programs should generally involve a gradual step down in services. Discharge from a comprehensive ABA treatment program often requires 6 months or longer, for example, an individual in a comprehensive treatment program might step down to a focused treatment to address a few remaining goals prior to transition out of treatment.

### **Behavior Analyst Certification Board, Inc**

The Behavior Analyst Certification Board, Inc (BACB) is a nonprofit 501(c)(3) corporation that was established in 1998 to meet professional credentialing needs identified by behavior analysts, governments and consumers of behavior analysis services. The BACB adheres to international standards for boards and grant professional credentials. The BACB certification procedures and content undergo regular psychometric review and validation, pursuant to a job analysis survey of the profession and standards established by content experts in the field.

The Behavior Analyst Certification Board's credentialing programs are accredited by the National Commission for Certifying Agencies in Washington, DC. NCCA is the accreditation body of the Institute for Credentialing Excellence.

**BACB's Mission:** Protect consumers of behavior analysis services by systematically establishing, promoting and disseminating professional standards.

### **Behavior Analyst Certification Board, Inc Credentials**

#### **Board Certified Behavior Analyst (BCAB, BCBA-D):**

The BCBA and BCBA-D are independent practitioners who also may work as an employee or independent contractors for an organization.

- **BCBA-D** - are board certified behavior analysts who have earned a Doctorate Degree and the BCBA-D certification with all the training and experience requirements set forth by the Behavioral Analyst Certification Board.
- **BCBA** – are board certified behavior analysts who have earned a Masters Degree and the BCBA certification with all the training and experience requirements set forth by the Behavior Analyst Certification Board.

#### **The BCBA or BCBA-D is primarily responsible for the following:**

- Conducts descriptive and systematic behavioral assessments, including functional analyses, and provides behavior analytic interpretations of the results.
- Designs and supervises behavior analytic interventions.
- Able to effectively develop and implement appropriate assessment and intervention methods for use in unfamiliar situations and for the range of cases.
- Seeks the consultation of more experienced practitioners when necessary.

- Teaches others to carry out ethical and effective behavior analytic interventions based on published research and designs and delivers instruction in behavior analysis.
- Supervise the work of Board-Certified Assistant Behavior Analysts (BCaBA) and others who implement behavior analytic interventions (Registered Behavior Technician (RBT)).

### **Board Certified Assistant Behavior Analyst (BCaAB)**

BCaBA is an undergraduate-level certification in behavior analysis. Professionals who are certified at the BCaBA level may not practice independently but must be supervised by someone at the BCBA/BCBA-D level. In addition, BCaBAs can supervise the work of Registered Behavior Technicians, and others who implement behavior-analytic interventions.

BCaBA - are board certified assistant behavior analysts who have earned a bachelor's degree and the BCaBA certification with all the training and experience requirements set forth by the Behavior Analyst Certification Board.

### **Registered Behavior Technician (RBT):**

The Registered Behavior Technician (RBT) is a paraprofessional who practices under the close, ongoing supervision of a BCBA or BCaBA. The RBT is primarily responsible for the direct implementation of behavior analytic services. The RBT does not design intervention or assessment plans. It is the responsibility of the RBT supervisor to determine which tasks an RBT may perform as a function of his or her training, experience and competence. The BACB certificant supervising the RBT is responsible for the work performed by the RBT on the cases they are overseeing.

RBT – must be at least 18 years of age, possess a minimum of a high school diploma or national equivalent, complete 40 hours of training, pass RBT Competency Assessment and pass the RBT exam.

## **Prior Approval**

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## Policy

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The intent of this medical policy is to address applied behavior analysis (ABA) therapy for the treatment of autism.

**Note:** The member's benefit plan determines coverage, applied behavior analysis (ABA) therapy for all other indications except for the treatment of autism will be considered a **non-covered benefit**.

Based upon evidenced based literature applied behavior analysis (ABA) therapy is an intensive treatment that is to be rendered face-to-face and on a 1:1 basis with the patient. Therefore, the following will be considered **not medically necessary or contract exclusion**:

- Group therapy formats (97154, 97157,97158)
- Telemedicine formats

Parent/Caregiver support is expected to be a component of the applied behavior analysis (ABA) therapy program, as they will need to provide additional hours of behavioral interventions. However, parent support groups are considered **not medically necessary or contract exclusion**.

### **ABA Therapy Provided Inpatient, Residential or Partial Hospitalization Settings**

If ABA therapy is being provided as part of the treatment plan in an inpatient, residential or partial hospitalization setting, medical necessity at that level of care will be inclusive of this therapy, an additional authorization specific to the ABA therapy is not needed.

If prior to discharge from one of these higher levels of care, if ongoing ABA therapy will be part of the patient's treatment plan a medical necessity review will need to be completed using the guidelines below for outpatient applied behavior analysis therapy.

### **Outpatient Applied Behavior Analysis Therapy**

**Coverage for applied behavior analysis may be subject to the following:**

- Care management requirements
- Subject to any deductibles, copayments or coinsurance provisions that apply to the medical or surgical services covered under the plan.
- ABA therapy services are subject to prior approval, however, prior approval does not guarantee coverage.

**Benefits are not available for the following:**

- Therapy duplicates services provided by educational setting and/or is part of scholastic education
- Treatment is not clinically appropriate in terms of type, frequency, extent, site and duration
- Treatment is primarily for the convenience of the patient, physician, or other health care provider (ABA is therapy, not babysitting)
- Member does not have the diagnosis of Autism Spectrum Disorder (ASD)

### Assessment and Initiation of Care Requests

The initial assessment for applied behavioral analysis (ABA) is considered **medically necessary** if **ALL** of the following criteria is met:

- Patient has a diagnosis of autism spectrum disorder (ASD) consistent with the DSM-5 criteria above; **and**
- Any person who is providing or supervising applied behavior analysis shall:
  - Be licensed as a medical doctor, doctor of osteopathy, or psychologist in the state in which the applied behavior analysis services are being performed; **or**
  - Behavior Analyst Certification Board, Inc (BACB) certified providers (undergraduate-level certification in behavior analysis must be supervised by someone certified at the BCBA/BCBA-D level; may supervise RBT's, and others who implement behavior-analytic interventions); **and**
- All initial assessments performed by a licensed behavior analyst (LBA)/certified behavior analyst. Preferred assessments must be developmentally and age appropriate and include the ABLLS, VB-MAPP, or other developmental measurements employed; **and**
- Functional Behavior Assessment to address targeted problematic behaviors with operational definition and provide data to measure progress, as clinically indicated.

The initiation for applied behavior analysis (ABA) therapy will be considered **medically necessary** if **ALL** of the following criteria is met:

**Note:** ABA therapy services determined to be medically necessary will be authorized for 6 months, unless it is determined that an earlier review is required, medical necessity review requests for the treatment of an individual receiving ABA therapy may be requested no more than every 3 months. For any additional ABA therapy services beyond this authorization time frame, the requesting provider will need to submit the prior approval request form and all the required information outlined below.

- The individual has a diagnosis of autism spectrum disorder (ASD) consistent with the DSM-5 criteria above; **and**
- Any person who is providing or supervising applied behavior analysis shall:
  - Be licensed as a medical doctor, doctor of osteopathy, or psychologist in the state in which the applied behavior analysis (ABA) services are being performed; **or**
  - Behavior Analyst Certification Board, Inc (BACB) certified providers; undergraduate-level certification in behavior analysis (RBT or BCaBA) who implement behavior-analytic interventions must be supervised by someone certified at the BCBA/BCBA-D level; **and**

- The ABA therapy (treatment modalities and interventions) recommended do not duplicate or replicate services received in a patient's primary academic educational setting, or available within an Individualized Education Plan (IEP) or Individualized Service Plan (ISP); **and**
- The ABA therapy (treatment modalities and interventions) do not duplicate services provided or available to the patient by medical providers (i.e. occupational therapy, speech therapy, physical therapy and any other applicable providers) or behavioral health professionals: **and**
- The approved treatment goals and clinical documentation must be focused on active ASD core symptoms and deficits that inhibit daily functioning; **and**
- If there is a history of ABA treatment, the provider(s) review the previous ABA treatment record to determine that a reasonable expectation of the patient is they are able to, or demonstrate the capacity to learn and generalize skills to assist in his or her independence and functional improvements; **and**
- For Comprehensive treatment, the requested ABA therapies are directed toward reducing the gap between the patient's chronological and developmental age such that the patient is able to develop or restore function to the maximum extent practical; **or**
- For Focused treatment, the requested ABA therapies are designed to reduce the burden of selected treatment targeted symptoms on the patient, family and other significant people in the environment, and to target increases in appropriate alternative behaviors; **and**
- The treatment is provided at the least restrictive and most clinically appropriate environment to safely, effectively and efficiently deliver care; **and**
- The treatment intensity does not exceed the patient's functional ability to actively participate in the ABA therapies; **and**
- The treatment is clinically appropriate and designed to meet the individualized needs of the patient with regards to type, frequency, intensity, extent, site, and duration of services; **and**
- The treatment is required for reasons other than the convenience of the patient, parents/caregiver(s)/guardian, or physician or other health care member; **and**
- The hours of ABA therapies provided per week must reflect the patient, parents/caregiver(s), provider(s) availability to participate in the treatment; **and**
- **The following clinical documentation is submitted for review:**

- All initial assessments performed by the licensed behavior analyst (LBA)/certified behavior analyst. Preferred assessments must be developmentally and age appropriate and include the ABLLS, VB-MAPP, or other developmental measurements employed; **and**
- The individualized treatment plan with clinically significant and measurable goals that clearly address the active signs and symptoms of the member's core deficits of ASD; **and**
- Goals should be written with measurable criteria that can be reasonably achieved within 6 months (**note**: a medical necessity review of the patients progress in meeting the objectives of the goals/individualized treatment plan will be reviewed every 6 months unless it is determined that an earlier review is required, medical necessity review requests for the treatment of an individual receiving ABA therapy may be requested no more than every 3 months); **and**
- Goals should include documentation of core symptoms of ASD identified on the treatment plan, date of treatment introduction, estimated date of mastery and a specific plan for generalization of skills; **and**
- Functional Behavior Assessment to address targeted problematic behaviors with operational definition and provide data to measure progress, as clinically indicated; **and**
- To reduce the likelihood of unnecessary duplication of services, the delivery of conflicting interventions or instructions, and the provision of more therapy hours than the patient may be able to tolerate, or benefit from, the following information should be included:
  - Types of therapies/services that will be provided in addition to the ABA therapy;
  - Number of therapies/services per week;
  - Behaviors and deficits targeted; **and**
- Documentation of treatment participants, treatment modalities and interventions and setting where the ABA services will be provided:
  - Caregiver (parent(s)/caregiver(s)/guardian) participation in at least 80% of scheduled training sessions. Caregiver training is defined as the education and development of caregiver-mediated ABA strategies, protocols, or techniques directed at facilitating, improving or generalizing social interaction, skill acquisition and behavior management, to include observational measures for assurance of treatment integrity
    - Caregiver training goals submitted for each authorization period must be specific to the patient's identified needs and should include goal mastery criteria, data collection and behavior management procedures if applicable, and procedures to address ABA principles such as reinforcement, prompting, fading, and shaping. Each goal should include date of introduction, current performance level, and specific plan for generalization;
    - Clinical rationale must be provided when less than 80% participation in scheduled caregiver training sessions occurs

during a review period to address any deficits in member generalization of acquired skills into non-clinical community settings: **and**

- 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 the patient's independence; **and**
- ABA principles utilized during caregiver training to achieve desired outcomes may include, but are not limited to reinforcement, task analysis, prompting, fading shaping and chaining; **and**
- Although not required for the initial ABA service request, transition and aftercare planning should begin during the early phases of treatment.

**Notes:**

- ABA therapy services are subject to prior approval, however, prior approval does not guarantee coverage.
- The authorization approval for ABA therapy services is not inclusive of other services being provided (i.e. occupational therapy, speech therapy, physical therapy, educational services (day care, preschool, school, early interventional services), etc.). The approval is specific to applied behavior analysis therapy.
- A medical necessity review of the individual's progress in meeting the objectives of the treatment plan shall be reviewed every six months unless it is determined that an earlier review is required, medical necessity review requests for the treatment of an individual receiving ABA therapy may be requested no more than every 3 months.
- Documentation of onsite supervision of the applied behavior analysis must be provided.

**Continuation of Treatment Request**

Continued ABA therapy will be considered **medically necessary** if **ALL** of the following criteria is met:

**Note:** ABA therapy services determined to be medically necessary will be authorized for 6 months, unless it is determined that an earlier review is required, medical necessity review requests for the treatment of an individual receiving ABA therapy may be requested no more than every 3 months. For any additional ABA therapy services beyond this authorization time frame, the requesting provider will need to submit the prior approval request form and all the required information outlined below.

- The individual has a diagnosis of autism spectrum disorder (ASD) consistent with the DSM-5 criteria above; **and**
- Any person who is providing or supervising applied behavior analysis shall:

- Be licensed as a medical doctor, doctor of osteopathy, or psychologist in the state in which the applied behavior analysis (ABA) services are being performed; **or**
  - Behavior Analyst Certification Board, Inc (BACB) certified providers; undergraduate-level certification in behavior analysis (RBT or BCaBA) who implement behavior-analytic interventions must be supervised by someone certified at the BCBA/BCBA-D level; **and**
- The ABA therapy (treatment modalities and interventions) recommended do not duplicate or replicate services received in a patient's primary academic educational setting, or available within an Individualized Education Plan (IEP) or Individualized Service Plan (ISP); **and**
- The ABA therapy (treatment modalities and interventions) do not duplicate services provided or available to the patient by medical providers (i.e. occupational therapy, speech therapy, physical therapy and any other applicable providers) or behavioral health professionals; **and**
- For Comprehensive treatment, the requested ABA therapies are directed toward reducing the gap between the patient's chronological and developmental age such that the patient is able to develop or restore function to the maximum extent practical; **or**
- For Focused treatment the requested ABA therapies are designed to reduce the burden of selected treatment targeted symptoms on the patient, family and other significant people in the environment, and to target increases in appropriate alternative behaviors; **and**
- The treatment is provided at the least restrictive and most clinically appropriate environment to safely, effectively and efficiently deliver care; **and**
- The treatment intensity does not exceed the patient's functional ability to actively participate in the ABA therapies; **and**
- The treatment is clinically appropriate and designed to meet the individualized needs of the patient with regards to type, frequency, intensity, extent, site, and duration of services; **and**
- The treatment is required for reasons other than the convenience of the patient, parents/caregiver(s)/guardian, or physician or other health care member; **and**
- The hours of ABA therapies provided per week must reflect the patient, parents/caregiver(s), provider(s) availability to participate in the treatment; **and**

- **The following clinical documentation is submitted for review:**
  - Collected data including but not limited to the following:
    - Celeration charts, graphs, non-standardized tests such as VB-MAPP, ABLLS or other developmentally appropriate assessments, progress notes that link to interventions of specific plan goals/objectives; **and**
  - Individualized treatment with clinically significant and measurable goals that clearly address the active signs and symptoms of the core deficits of ASD; **and**
  - Goals should be written with measurable criteria that can be reasonably achieved within 6 months; **and**
  - Goals should include documentation of core symptoms of ASD identified in 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; **and**
  - Functional Behavior Assessment to address targeted problematic behaviors with operation definition and provide data to measure progress, as clinically indicated; **and**
  - To reduce the likelihood of unnecessary duplication of services, the delivery of conflicting interventions or instructions, and the provision of more therapy hours than the patient may be able to tolerate, or benefit from, the following information should be included:
    - Types of therapies/services that will be provided in addition to the ABA therapy;
      - Number of therapies/services per week
      - Behaviors and deficits targeted
      - Progress related to treatment/services being provided; **and**
  - Transition and discharge planning.\*

On the concurrent/continuation review, the current ABA therapy will need to demonstrate significant improvement and clinically significant progress to develop and restore the function of the patient:

- Significant improvement is defined as the following: mastery of a minimum of 50% of stated goals found in the submitted treatment plan. Adaptive behavior, cognitive and/or language testing must show evidence of measurable functional improvement, as opposed to declining or plateaued scores; **or**
- For a patient who does not master 50% of stated goals and/or fail to demonstrate measurable and substantial evidence toward developing or restoring the maximum function, the treatment plan should clearly address the barriers to treatment success; **and**
- There is reasonable expectation of mastery of proposed goals within the requested 6 month treatment period and that achievement of goals will assist in the patients independence and functional improvements; **and**

- There is reasonable expectation that the patient is able to, or demonstrates the capacity to, acquire and develop clinically significant generalized skills to assist in his or her independence and functional improvements.

### **Describing Measurable Progress Toward Goals**

- When describing measurable progress towards goals, describe goal and current performance using specific measurable performance as compared to baseline performance (for example: A goal for percentage of time the individual follows a two-step direction during instructional session was 80 percent. Baseline performance was 10 percent, current performance is 60 percent).

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

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

### **Notes:**

- The authorization approval for ABA therapy services is not inclusive of other services being provided (i.e. occupational therapy, speech therapy, physical therapy, educational services (day care, preschool, school, early interventional services), etc.). The approval is specific to applied behavior analysis therapy.
- Documentation of onsite supervision of the applied behavior analysis services must be provided.
- A medical necessity review of the individual's progress in meeting the objectives of the treatment plan shall be reviewed every six months unless it is determined that an earlier review is required, medical necessity review requests for the treatment of an individual receiving ABA therapy may be requested no more than every 3 months.
- ABA therapy services are subject to prior approval, however, prior approval does not guarantee coverage.

## Discharge Criteria for Applied Behavior Analysis (ABA) Therapy Services

If any of the following criteria are met the patient will be considered discharged and any further ABA therapy services will be considered **not medically necessary**.

- Based on documentation provided the patient shows improvement from baseline in targeted skill deficits and behaviors such that goals are achieved or maximum benefit has been reached.
- Based on the documentation provided there has been no clinically significant progress/measurable improvement for a period of at least 3 months in the patient's behavior(s) or skill deficits in any of the following measures:
  - Adaptive functioning
  - Communication/Language skills
  - Social/family interactions
  - Behaviors interfering with functioning/relationships
    - Repetitive restrictive behaviors
    - Disruptive/aggressive self-injurious behaviors
- The treatment is making the skill deficits and/or behaviors persistently worse.
- The patient is not making progress toward goals and is unlikely the patient will continue to benefit or maintain long term gains from proposed plan of treatment.
- Parent(s)/caregiver(s)/guardian have refused the treatment recommendations or are unable to participate in the treatment program and/or do not follow through on treatment recommendations to a degree that compromises the effectiveness of the services prescribed/proposed.

### Policy Guidelines

#### Definitions

**Baseline Data:** Objective and quantitative measures of the percentage, frequency or intensity and duration of skill/behavior prior to intervention.

**Clinical Significance:** Clinical significance is the measurement of practical importance of treatment effect- whether it creates a meaningful difference and has an impact that is noticeable in daily life.

**Comprehensive ABA Treatment:** Comprehensive ABA refers to treatment of the multiple affected developmental domains, such as cognitive, communicative, social, emotional, and adaptive 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.



**Duration:** Treatment duration is effectively managed by evaluating the clients response to treatment. This evaluation can be conducted prior to the conclusion of the authorization period. Some individuals will continue to demonstrate medical necessity and require continued treatment across multiple authorization periods.

**Focused ABA Treatment:** Focused ABA refers to treatment provided directly to the client for a limited number of behavioral targets. It is not restricted by age, cognitive level, or co-occurring conditions. Focused ABA treatment may involve increasing socially appropriate behavior (for example, increasing social initiations) or reducing problem behavior (for example, aggression) as the primary target. Even when reduction of problem behavior is the primary goal, it is critical to also target increases in appropriate alternative behavior, because the absence of appropriate behavior is often the precursor to serious behavior disorders.

**Functional Analysis:** Empirically supported process of making systematic changes to the environment to evaluate the effects of the four testing conditions of play (control), contingent attention, contingent escape and the alone condition, on the target behavior, which allows the practitioner to determine the antecedents and consequences maintaining the behavior.

**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 patient's caregiver(s); having caregivers complete checklists, rating scales or questionnaires; and/or observing and recording occurrences of target behaviors and environmental events in everyday situations.

**Generalization:** Skills acquire in one setting are applied to many contexts, stimuli, materials, people, and/or settings to be practical, useful, and functional for the patient. Generalized behavior change involves systematic planning and needs to be a central part of every intervention and every caregiver training strategy.

**Intensity:** Will vary with each individual and should reflect goals of treatment, specific needs of the individual, and responses to treatment. Intensity is typically measured in terms of hours per week of direct treatment. Intensity often determine whether the treatment falls into the category of either Focused or Comprehensive.

**Interpersonal Care:** Interventions that do not diagnose or treat a disease, and that provide either improved communication between individuals, or a social interaction replacement.

**Mastery Criteria:** Objectively and quantitative stated percentage, frequency or intensity and duration in which a patient must display skill/behavior to be considered an acquired skill/behavior.

**Neurological Evaluation:** 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 activity

**Nonstandardized Instruments:** Include, but not limited to, curriculum-reference assessment, stimulus-preference-assessment procedures, and other procedures for assessing behaviors and associated environmental events that are specific to the individual patient and behaviors.

**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. 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.

### **Procedure Codes and Billing Guidelines**

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*To report provider services, use appropriate CPT\* codes, Alpha Numeric (HCPCS level 2) codes, Revenue codes and / or diagnosis codes.*

- 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 the 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 Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician and other qualified health care professional with the assistance of one or more technicians; first 30 minutes of technician(s) time, face-to-face with the patient.
- 0373T Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians time, face-to-face with patient.

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### Policy History

Date	Reason	Action
December 2016		New Policy Created
January 2017	Interim Review	Policy Revised
March 2017	Interim Review	Policy Revised
December 2017	Annual Review	Policy Revised
December 2018	Annual Review	Policy Renewed
December 2019	Annual Review	Policy Revised
February 2020	Interim Review	Policy Revised
May 2020	Interim Review	Policy Revised
December 2020	Annual Review	Policy Renewed

