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Medical Policy Manual Behavioral Health, Policy No. 18

Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder

Effective: June 1, 2023

Next Review: April 2024
Last Review: April 2023

IMPORTANT REMINDER

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

DESCRIPTION

Applied Behavior Analysis (ABA) is an umbrella term describing principles and techniques used in the assessment, treatment, and prevention of challenging behaviors and the promotion of new desired behaviors. The goal of ABA is to teach new skills, promote generalization of these skills, and reduce challenging behaviors with systematic reinforcement.

MEDICAL POLICY CRITERIA

Note: This policy only applies to member contracts that are subject to preauthorization for Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder, as specified by their group plan. Please check the preauthorization website for the member contract to confirm requirements.

I. Initiation of Applied Behavior Analysis (ABA)-based therapy may be considered **medically necessary** when all of the following criteria (A. - C.) are met:

A. An ABA assessment has been documented and all of the following criteria (1. - 3.) are met:

1. The member has a diagnosis of an Autism Spectrum Disorder according to

the DSM (Diagnostic and Statistical Manual of Mental Disorders), either the DSM-IV or DSM-5 (see Policy Guidelines), by a licensed provider experienced in the diagnosis and treatment of autism; and

2. The Autism Spectrum Disorder (ASD) related symptoms and behaviors are impairing the member's communication, social and/or behavioral functioning such that the member is a safety risk to self or others and/or is unable to participate in age-appropriate home or community activities; and
3. ABA therapy must be recommended or prescribed by a licensed provider experienced in the diagnosis and treatment of autism.

B. Based upon the recommendation or prescription from the prescribing provider, a documented individualized treatment plan (ITP) is prepared by the treating provider who is certified to provide ABA therapy. An ITP shall be documented in the medical record; and

C. The individualized treatment plan (ITP) shall include all of the following (1. - 7.):

1. A detailed description of specific behaviors targeted for therapy. Targeted behaviors must be those which prevent the member from participating in age-appropriate home or community activities and/or are presenting a safety risk to self or others; and
2. For each targeted behavior, an objective baseline measurement using standardized instruments that include frequency, intensity and duration; and
3. A detailed description of treatment interventions and techniques specific to each of the targeted behaviors, including the frequency and duration of treatment for each intervention which is designed to improve the member's ability to participate in age-appropriate home or community activities and/or reduce the safety risk to self or others; and
4. Where there was a prior course of ABA therapy, documentation will specify the anticipated benefit of an additional course of treatment; and
5. A description of training and participation of family (parents, legal guardians and/or active caretakers as appropriate) in setting baseline and demonstrating progress toward treatment goals that directly support member's ITP; and
6. Clinical justification for the number of days per week and hours per day of direct ABA services provided to the member and the family, and the hours per week of direct face-to-face supervision of the treatment being delivered and observation of the child in their natural setting; and
7. Individualized and measurable discharge and/or transition criteria.

II. Continuation of ABA-based therapy may be considered **medically necessary** when there has been functional and measurable progress in the ITP goals, demonstrated when all of the following criteria (A. - D.) are met:

A. Member continues to meet Criteria I.B. and I.C. above; and

B. Data on targeted behaviors is documented by the individuals who are delivering the prescribed or recommended ABA therapy to the member during each ABA session. The treating provider who is certified to provide ABA therapy will

routinely collate and evaluate the data from all sessions and conduct a case review and treatment plan review; and

C. Progress toward each of the defined goals in the ITP is assessed and documented for each targeted behavior regarding whether clinically significant improvements are achieved and sustained both during treatment sessions and outside the treatment setting (e.g. home/community). Progress toward the ITP goals is measured using the same indices utilized for baseline measurements in the ITP; and

D. Objective measurements using standardized instruments that include frequency, intensity, and duration and evaluation to occur at a minimum of every six months.

III. Initial or continued ABA-based therapy for all indications is considered **not medically necessary** when the above applicable criteria are not met.

NOTE: A summary of the supporting rationale for the policy criteria is at the end of the policy.

POLICY GUIDELINES

APPLICABLE BENEFITS

This policy applies to member contracts with applicable benefits subject to the following:

- Washington's Mental Health Parity Act (RCW 48.44); or
- Oregon's Mental Health Parity Act (ORS 743.168) effective August 8, 2014; or
- Idaho's Clarification Regarding Coverage of Treatments for Autism Spectrum Disorder (Bulletin No. 18-02), or
- Utah's Autism Services Amendment, SB 57 (UCA 31A-22-642) effective 2016.

CERTIFIED PROVIDERS

Treating providers who are certified to provide ABA therapy include a qualified Lead Behavior Analysis Therapist (LBAT), and in Idaho, a credentialed provider with a Board-Certified Behavioral Analysis (BCBA) certification issued by the Behavioral Analyst Certification Board.

TREATMENT EXPECTATIONS

At least every three months, the LBAT, or in Idaho, a credentialed provider with a Board Certified Behavioral Analysis (BCBA) certification issued by the Behavioral Analyst Certification Board, should assess the member and update the individualized treatment plan (ITP) as indicated by the member's response to therapy and obtain review by the Prescribing Provider or another licensed provider who has experience in the diagnosis and treatment of autism.

LIST OF INFORMATION NEEDED FOR REVIEW

SUBMISSION OF DOCUMENTATION

The following information may be required for review of ABA services:

Initiation

- Documentation of the following from the prescribing provider (Criteria I.A.1. and I.A.2., above):
  - Diagnosis of Autism Spectrum Disorder (ASD)
  - ASD is impairing the member's functioning such that the member is a safety risk and/or is unable to participate in age-appropriate activities
- Written recommendation, clinical order, or prescription for ABA services from the provider (Criteria I.A.3., above)
- Individualized treatment plan (ITP) with the information listed in Criteria I.C.1.-7., above
- List of specific services requested with the number of units/hours requested per specified period of time

Continuation

The following documentation should be submitted within five business days prior to the end of a current authorization:

- Updated ITP with the information listed in Criteria II.A.-C., above

CROSS REFERENCES

1. Applied Behavior Analysis Initial Assessment for the Treatment of Autism Spectrum Disorder, Behavioral Health, Policy No. 33

BACKGROUND

AUTISM SPECTRUM DISORDER

Autism Spectrum Disorder (ASD) is a neurodevelopment disorder characterized by impaired social communication and interaction and atypical interests and behavioral patterns. ASD may be accompanied by other conditions, such as epilepsy and cognitive impairment. As defined by the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), ASD includes:[1]

- Autistic Disorder
- Asperger's Disorder
- Pervasive Developmental Disorder, Not Otherwise Specified (PDD-NOS)

Diagnostic criteria for ASD as defined by the DSM-5[1], are listed in Appendix 1.

BEHAVIORAL INTERVENTIONS FOR AUTISM SPECTRUM DISORDER

A number of behavioral interventions (e.g., educational, medical, behavioral, complementary, and other allied health interventions) aiming to improve core social, communication and challenging behaviors are available. Several treatments for ASD have been developed based upon different treatment principles, such as applied behavior analysis (ABA) as described below. With the exception of two treatment therapies (UCLA/Lovaas and Early Start Denver Model), most ABA intervention protocols have not been manualized, resulting in the potential for practice and treatment variation.

Applied Behavior Analysis

ABA may be defined as: “the design, implementation and evaluation of environmental modifications, using behavioral interventions for the treatment of autism spectrum disorder. The goal of the therapy is to produce clinically significant improvements in core deficits associated with autism spectrum disorder (i.e. significant issues with communication, social interaction or injurious behaviors). It includes the use of direct observation, measurement and functional analysis of the relationship between the environment and behavior and uses behavioral stimuli and consequences.”

The majority of the research supporting the use of ABA has been conducted in children; although there is some evidence of the effectiveness of ABA in adults (18 years and older), the evidence is less robust and definitive, warranting closer review.[2, 3]

Early Intensive Behavioral Intervention

Early intensive behavioral interventions incorporate principles of ABA but differ in methods and settings. There are two intensive, manualized ABA-based early intervention programs intended to improve the challenging behaviors specifically associated with ASD that include University of California, Los Angeles (UCLA/Lovaas and the Early Start Denver model).

SUMMARY

Applied Behavior Analysis (ABA) is applied in the assessment, treatment, and prevention of challenging behaviors and the promotion of new desired behaviors. This method of treatment is often used for Autism Spectrum Disorder (ASD). Individual states have mandated requirements for the assessment and treatment of ASD, which the policy criteria align with. Therefore, ABA may be considered medically necessary for the initiation and continuation of treatment for ASD when policy criteria are met. When policy criteria are not met, ABA for ASD is considered not medically necessary.

REFERENCES

1. American Psychiatric Association (2013): Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Arlington VA: American Psychiatric Press.
2. Bishop-Fitzpatrick L, Minshew NJ, Eack SM. A systematic review of psychosocial interventions for adults with autism spectrum disorders. *Journal of autism and developmental disorders.* 2013;43(3):687-94. PMID: 22825929
3. Wong C, Odom SL, Hume KA, et al. Evidence-Based Practices for Children, Youth, and Young Adults with Autism Spectrum Disorder: A Comprehensive Review. *Journal of autism and developmental disorders.* 2015;45(7):1951-66. PMID: 25578338

CODES

Codes	Number	Description
CPT	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;

Codes	Number	Description
		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 destructive behavior; completion in an environment that is customized to the patient's behavior
	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
HCPCS	None	

APPENDIX 1

Diagnostic and Statistical Manual of Mental Disorders, *5th Edition* (DSM-5)

Autism Spectrum Disorder, 299.00 (F84.0)

Diagnostic Criteria

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, see text):

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1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social 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 nonverbal 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 Table 1).

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat 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 interest).
4. Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

Specify current severity:

Severity is based on social communication impairments and restricted, repetitive patterns of behavior (see Table 1).

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

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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 developmental 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.

Note: Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder.

Specify if:

With or without accompanying intellectual impairment

With or without accompanying language impairment

Associated with a known medical or genetic condition or environmental factor

Table 1. Severity levels for autism spectrum disorder

Severity level	Social communication	Restricted, repetitive behaviors
Level 3 "Requiring very substantial support"	Severe deficits in verbal and nonverbal social communizations skills cause severe impairment sin 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 changing focus or action.
Level 2 "Requiring substantial support"	Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others. 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.
Level 1 "Requiring support"	Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical	Inflexibility of behavior causes significant interference with functioning in one or more contexts.

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	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 other fails, and whose attempts to make friends are odd and typically unsuccessful.	Difficulty switching between activities. Problems of organization and planning hamper independence.

Date of Origin: *January 2012*