Applied Behavior Analysis

MEDICAL POLICY NUMBER: 288

Effective Date: 3/1/2024

Last Review Date: 2/2024

Next Annual Review: 2/2025

INSTRUCTIONS FOR USE: Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Company reserves the right to determine the application of medical policies and make revisions to medical policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

SCOPE: Providence Health Plan, Providence Health Assurance and Providence Plan Partnersas applicable (referred to individually as “Company” and collectively as “Companies”).

PLAN PRODUCT AND BENEFIT APPLICATION

☒ **Commercial** ☒ **Medicaid/OHP*** ☐ **Medicare****

*Medicaid/OHP Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

**Medicare Members

This *Company* policy may be applied to Medicare Plan members only when directed by a separate *Medicare* policy. Note that investigational services are considered **"not medically necessary"** for Medicare members.

COVERAGE CRITERIA

Carelon, in cooperation with participating health plans will facilitate access to Applied Behavior Analysis (ABA) services to covered beneficiaries who meet medical necessity criteria outlined by the state and federal guidelines below. This effort will include assistance with identification of potential candidates from this population that could benefit from ABA services. As individuals are identified, Carelon will insure timely access with a qualified service provider within the network.

InterQual® criteria are used in conjunction with this policy to determine the medical necessity of ABA services. A copy of these criteria are available upon request.

Procedure

I. Initial request for ABA service may come from a health plan, provider, parent or other legal guardian by contacting the member services number that supports Carelon.

II. Member Services responds to calls to verify benefits and gather the following information:
- Member Name
- Member age / Date of Birth
- Parent/Legal Guardian name
- Contact information
- Address (include County)
- Referral source
- Previous Diagnosis, if available
- Group Name and ID for subscriber
- Treatment history, if any

III. If a patient has not been evaluated and diagnosed by a licensed provider who has experience and training in ABA and there is no treatment history, the parent/caregiver is assisted with referrals to a licensed provider who has experience and training in ABA who can complete a Diagnostic Evaluation and make treatment recommendation for ABA services.

IV. If a patient has been evaluated and diagnosed by a licensed provider who has experience and training in ABA who has made a recommendation for ABA services, referrals are provided to the family of ABA Providers.

V. The qualified service provider (BCBA) within the network, once authorization is granted by Carelon, will schedule the initial functional behavior assessment.

VI. Carelon requires a qualified provider (BCBA) to develop the ABA treatment plan and supervise all direct ABA services.

Authorization Process

VII. Following the face-to-face assessment, the qualified service provider submits one or more of the following to Carelon for ABA services:

- Comprehensive Assessment and Observation or Exposure Follow-up
- Development of Treatment Plan
- Supervision hours by a Qualified Service Provider (BCBA) to a Qualified Service Professional (BCaBA) or Qualified Services Paraprofessional.
- ABA Therapy – direct member care
- Social Skills Group
- Parent/Caregiver Training Without the Patient Present
- Parent/Caregiver Training with the Patient Present

VIII. Carelon reviews the request applying the Level of Care (InterQual®) criteria for ABA, while taking into account the biopsychosocial factors affecting the child.[1] If the authorization is denied by InterQual due to anything other than medical necessity (age, diagnosis, parental involvement, etc.), the case is reviewed by a supervisory clinician and subsequently an MD if further evaluation is needed. The MD determines if the services meet medical necessity criteria and at what level of care.

IX. Services are delivered in accordance with the recipient's treatment plan. The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified service provider for the specific patient being treated. The treatment plan must identify the service type, number of hours, parent/caregiver participation needed to achieve the plan's goals and objectives, and the individual providers responsible for providing the service. The treatment plan must incorporate training and support and include active participation from the patient's parent/caregiver. Treatment plan interventions identify, emphasize, and focus on generalization of skills and the development of spontaneous social communication, adaptive skills, and appropriate behaviors. The treatment plan must be made available to Carelon upon request. All treatment interventions must be consistent with ABA best practices. Treatment must be provided in a home or community-based setting, including clinics. The behavioral treatment plan must:

A. Be developed by a qualified service provider licensed to provide ABA services for the specific beneficiary being treated;
B. Include a description of patient information, reason for referral, brief background information (demographics, living situation, home/school/work information), clinical interview, review of recent assessment/reports, assessment procedures and results and focused or comprehensive ABA requirements;
C. Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors;
D. Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives;
E. Utilize evidence-based ABA services with demonstrated clinical efficacy, tailored to the beneficiary;
F. Clearly identify the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the beneficiary's progress is measured and reported, transition plan, crisis plan and the individual providers responsible for delivering the services;
G. Include care coordination involving the parents or caregiver(s), school, state disability programs and others as applicable;
H. Consider the beneficiary's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision;
I. Deliver ABA services in a home or community-based setting, including clinics. Any portion of medically necessary ABA service that is provided in school must be clinically indicated as well as proportioned to the total ABA services received at home and community; and
J. Include an exit plan/criteria.

X. Treatment updates are documented weekly by the service provider and are provided to Carelon no less frequently than every 6 months.

XI. The treatment plan must document the number of service hours needed to effectively address the challenging behaviors identified. At a minimum, there must be at least one hour of supervision provided by a qualified service provider for each 10 hours of direct service provided by a service professional or service paraprofessional.

XII. Services must give consideration to the child's age, school attendance requirements and other daily activities as documented in the treatment plan.

State Specific Requirements

Oregon[2,3]

XIII. For clients covered by those health plans originating in the State of Oregon and subject to the contract, insurance laws and regulations of the State of Oregon, Carelon shall comply with all applicable federal, State and local laws and Regulations.
XIV. Coverage Determinations:

A. A health plan must adjudicate ASD and PDD claims as mental health claims subject to state and federal mental health parity laws.
B. The health plan may not categorically deny treatment for ABA therapy on the basis that the treatment is investigational.
C. A health plan may not apply a categorical exclusion (such as exclusions for developmental, social or educational therapies) that results in a denial of all ABA or other medically necessary treatment.
D. In order to comply with Mental Health Parity and Addiction Equality Act (MHPAEA) of 2008, the health plan has chosen not to implement any age or hour restrictions in benefit administration of ABA. Coverage decisions must be made on the basis of individualized determinations of medical necessity and must meet federal parity standards (refer to INS 2014-1, OAR 836-053-1405 and SB 365).

XV. ABA services may be provided by any licensed health care professional whose training and scope of practice includes applied behavior analysis services.

XVI. The State of Oregon delegates the need for treatment plan approval by a licensed health care professional to the health insurance carrier.

XVII. If an individual is receiving applied behavior analysis, an insurer may require submission of an individualized treatment plan. An insurer may require an updated individualized treatment plan, not more than once every six months.

The health plan may require the individualized treatment plan to be approved by a professional described in subsection (2)(a), and to include the:

A. Diagnosis;
B. Proposed treatment by type;
C. Frequency and anticipated duration of treatment;
D. Anticipated outcomes stated as goals, including specific cognitive, social, communicative, self-care and behavioral goals that are clearly stated, directly observed and continually measured and that address the characteristics of the disorder; and
E. Signature of the treating provider.

Washington

XVIII. For clients covered by those health plans originating in the State of Washington and subject to the contract, insurance laws and regulations of the State of Washington, Carelon shall comply with all applicable federal, State and local laws and Regulations.

XIX. Coverage Determinations:

- For the purposes of this section, "mental health services" means medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders (reference RCW 48.44.341)

Prohibited exclusions that apply to ABA:

- Benefits for actual treatment and services rendered may not be denied solely because a course of treatment was interrupted or was not completed.

- If a service is prescribed for a mental health condition and is medically necessary, it may not be denied solely on the basis that it is part of a category of services or benefits that is excluded by the terms of the contract.
- Benefits for mental health services and substance use disorder may not be limited or denied based solely on age or condition.
- Coverage is not limited by age, dollar, or number of visits.

POLICY CROSS REFERENCES

None

The full Company portfolio of current Medical Policies is available online and can be accessed here.

POLICY GUIDELINES

BACKGROUND

ABA as a treatment is used to help a child or adolescent learn appropriate social behaviors and improve and increase their communication and learning skills and capabilities. ABA is a treatment intervention developed from principles of behavioral psychology that teaches complex and simple skills based on consequences and reinforcement to improve social and functional behaviors that are targeted, observable, and measurable. ABA is commonly used as a type of therapy for children diagnosed with autism spectrum disorder or other developmental conditions.

BILLING GUIDELINES AND CODING

CODES*		
CPT	0362T	Behavior Exposure identification behavioral supporting follow-up assessment, each includes 15 physician minutes or of other technicians' qualified time health face-to-face care with professional a direction patient, with requiring interpretation the and following report, components: administered administration by the physician or other qualified health care professional who is on site; with the assistance of two one or more technicians; for first a 30 patient minutes who of exhibits technician(s) destructive time, behavior; completion in an environment that is customized face- to -face with 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	

***Coding Notes:**

- The above code list is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit.
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

1. InterQual® Behavioral Health Services: Applied Behavior Analysis (ABA) Program. *Critieria available upon request*. Accessed 12/7/2023.
2. ABA Bulletin 2014-2. https://dfr.oregon.gov/laws-rules/Documents/Bulletins/bulletin2014-02.pdf. Accessed 12/7/2023.
3. Senate Bill 365 https://olis.leg.state.or.us/liz/2013R1/Downloads/MeasureDocument/SB365/Enrolled. Accessed 12/7/2023.

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
2/2023	Converted to new policy template.
3/2023	Annual Update. Separated policy by line of business. Changed Beacon to Carelon.
6/2023	Interim update to clarify PA requirement language.
3/2023	Annual Update. Changes to verbiage in criteria.