



Applied Behavior Analysis (ABA)

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Introduction & Instructions for Use

Introduction

Supplemental Clinical Criteria are a set of objective and evidence-based behavioral health criteria used by medical necessity plans to standardize coverage determinations, promote evidence-based practices, and support members’ recovery, resiliency, and wellbeing for behavioral health benefit plans that are managed by Optum® .

Instructions for Use

This guideline is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning for behavioral health benefit plans managed by Optum. When deciding coverage, the member’s specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member’s benefits prior to using this guideline. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this guideline and the member’s specific benefit, the member’s specific benefit supersedes this guideline. Other clinical criteria may apply. Optum reserves the right, in its sole discretion, to modify its clinical criteria as necessary using the process described in Clinical Criteria.

This guideline is provided for informational purposes. It does not constitute medical advice.

Optum may also use tools developed by third parties that are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice. Optum may develop clinical criteria or adopt externally-developed clinical criteria that supersede this guideline when required to do so by contract or regulation.

Benefit Considerations

Before using this policy, please check the member-specific benefit plan document and any federal or state mandates, if applicable.

State Mandates

For *California Commercial* members:

A health care service plan shall not limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public entitlement program, including, but not limited to, special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance. It shall not include or enforce a contract that otherwise covered benefits on the basis that those services should be or could be covered by a public entitlement program.

Behavioral health treatment provided pursuant to a treatment plan for pervasive developmental disorder or autism is administered by a qualified autism service professional to include a psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor. This service professional must also meet the criteria for a Behavioral Health Professional set forth in the regulations that will be adopted by the California State Department of Developmental Services.

For *Connecticut* members refer to the following:

Behavioral therapy is "supervised by" such licensed behavior analyst, licensed physician or licensed psychologist when such supervision entails at least one hour of face-to-face supervision of the autism spectrum disorder services provider by such licensed behavior analyst, licensed physician or licensed psychologist for each ten hours of behavioral therapy provided by the supervised provider.

For *Florida* members, mid and large group fully insured (does not include individual and small) refer to the following:

Applied Behavior Analysis (ABA) is covered for the treatment of Down Syndrome. Speech therapy, physical therapy, occupational therapy, and ABA must be covered to the same extent as the existing Florida autism mandate.

For *Indiana* members refer to the following:

Services are intensive and may be provided daily. All determinations must be based on the individualized objectives of the treatment plan and unique needs of the member. No quantitative benefit coverage limitations are implied by reference to these guidelines. The intensity of service should consider the member's ability to participate, benefit, and tolerate the full spectrum of Services received concurrently including non-behavioral services such as school, speech and occupational therapies. Treatment intensity should be increased or decreased based on the member's response and current needs.

For fully insured policies in *Maryland*:

Use the following criteria as specified in the Code of Maryland Regulations (MD COMAR 31.10.39.03. April 3, 2014):

- A. Applied Behavioral Analysis (ABA) services include behavioral health treatment, psychological care, and therapeutic care of members diagnosed autism spectrum disorder.
- B. The following are required for the initiation and continuation of ABA services:
 1. A comprehensive evaluation of a child by the child's primary care provider or specialty physician identifying the need for treatment of autism spectrum disorder.

2. A prescription from a child's primary care provider or specialty physician that includes specific treatment goals.
 3. Annual review by the prescribing primary care provider or specialty physician, in consultation with the ABA provider, that includes:
 - i. Documentation of benefit to the child;
 - ii. Identification of new or continuing treatment goals; and
 - iii. Development of a new or continuing treatment plan.
- C. Applied Behavioral Analysis (ABA) Services that meet the above criteria will not be denied solely on the number of hours of habilitative services prescribed for:
1. Up to 25 hours per week for members between the ages of 18 months and 5 years old.
 2. Up to 10 hours per week for members between the ages of 6 and 18 years old
 3. Additional hours of ABA services will be authorized if determined to be medically necessary and appropriate. After exhausting benefits to the extent mandated by Maryland regulations, Optum will review requests for additional treatment using the medical necessity guidelines in its standard policy.
 4. Services are only delivered by providers who are licensed, certified, or otherwise authorized under the Health Occupations Article or similar licensing, certification, and authorization requirements of another state or U.S. territory where ABA services are provided.
- D. Location of Services
1. ABA services are not denied if the treatment plan identifies the child's school as the location of services.
 2. Services are not authorized under an Individualized Education Program (IEP), or any obligation imposed on a public school by the Individuals with Disabilities Education Act.
- E. ABA will not be denied on the basis that it is experimental or investigational.

For *Massachusetts Medicaid Early Intervention (EI)* members (Effective 10/01/2021):

- ABA services should not exceed 30 hours per week.
- It is required that supervision by a Board-Certified Behavior Analyst (BCBA) to a paraprofessional will be provided at the 1:10 ratio (one hour of supervision to ten hours of direct service). The supervision of paraprofessionals providing direct ABA services to a child may require that both the direct service provider and the supervisor be present at the same time during the home visit.

For *New Jersey Medicaid* members:

The need for ABA services must be determined by a qualified healthcare professional (QHP) capable of making a diagnosis of autism, such as a physician or psychologist. A comprehensive diagnostic evaluation is not required to access ABA services. ABA services are available to any child diagnosed with autism spectrum disorder as defined by ICD-10 diagnoses F84.0 through F84.9. ABA services shall be made available to children 18 months to 21 years of age based on medical necessity. Once a child has a diagnosis of autism (by a physician or psychologist), then a QHP such as a Board Certified Behavior Analyst (BCBA) will assess the child to determine the need for ABA therapy and to develop a treatment plan. It is not uncommon for one QHP to make the diagnosis (such as a physician) and a separate QHP (such as a BCBA) to develop and supervise the treatment plan.

- Acceptable QHPs for the diagnosis and treatment planning for adaptive behavior services include:
 - Physicians (diagnosis and treatment planning)
 - Psychologists trained and certified in behavior analysis, and (diagnosis and treatment planning)
 - Board Certified Behavior Analysts (treatment planning)

For *New York Medicaid* members (Effective 01/01/2023):

- Enrollees may be eligible for ABA if they are under age 21 and have received a diagnosis of autism spectrum disorder and/or Rett Syndrome as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).
- The NYS Medicaid member must be referred for ABA services by a NYS-licensed and NYS Medicaid-enrolled physician, psychologist, psychiatric nurse practitioner, pediatric nurse practitioner, or physician assistant.
- ABA services are provided by Licensed Behavior Analyst (LBA), Certified Behavior Analyst Assistant (CBAA) working under the supervision of LBAs, or other individuals specified under Article 167 of NYS education law.

- LBAs may form a group practice. CBAs may work in a group practice but cannot own a group practice.
- LBAs and CBAs may work in any setting that may legally provide ABA services. Examples of such settings may include: private practice, settings where patients/clients reside full-time or part-time, clinics, hospitals, residences, and community settings.

For *Ohio Medicaid* members:

- ABA is available through telehealth under the current guidelines effective June, 2018. If the provider is not enrolled with Medicaid, a single case agreement would be needed, see Ohio Administrative Code for list of eligible practitioners and prior authorization requirements, if applicable.

For *Pennsylvania Commercial* members:

- Health insurance coverage is required for the diagnosis and treatment of ASD for individuals less than 21 years old. The State of Pennsylvania Professional Licensing allows for supervision of ABA by a Board-Certified Behavior Analyst (BCBA) or a licensed behavior consultant, which is not required to be a traditionally licensed clinician.

For *Virginia Commercial* fully-insured HMO and insurance plans (Effective 07/01/2022):

- "Autism spectrum disorder" means any pervasive developmental disorder, as defined in the most recent edition or the most recent edition at the time of diagnosis of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.
- "Medically necessary" means in accordance with the generally accepted standards of mental disorder or condition care and clinically appropriate in terms of type, frequency, site, and duration, based upon evidence and reasonably expected to do any of the following: (i) prevent the onset of an illness, condition, injury, or disability; (ii) reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability; or (iii) assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capacities that are appropriate for individuals of the same age.

For *Washington Medicaid* members:

- Qualifying diagnosis - A diagnosis of an ASD, as defined by the DSM, or other developmental disability for which there is evidence ABA is effective.
- There is no age requirement to be eligible for ABA services.
- ABA services may be provided in an inpatient setting (emergency department, inpatient hospital, etc.) when the following criteria is met, in addition to all other criteria for ABA services in WAC 182-531A:
 - The services are ordered by an ABA Center of Excellence (COE) provider (developmental pediatrician, neurologist, pediatric neurologist, psychiatrist, pediatric psychiatrist, licensed psychologist or other qualified medical provider designated by HCA as a COE). Services may be medically necessary if:
 - Less costly and less intrusive interventions have been tried and were not successful or there is no equally effective and substantially less costly alternative treatment available
 - The evaluating and prescribing provider believes that there is a reasonable expectation that the requested ABA services will result in measurable improvement in the client's behavior or skills
 - The client's severe harmful behavior is preventing discharge to a less restrictive setting
 - The hospitalization or continued hospitalization has occurred as a result of the client's severe harmful behavior.
 - ABA provided in an inpatient setting must be a short-term, focused treatment to stabilize the client's harmful behavior to a level/intensity that promotes discharge to a less restrictive setting.
 - Care coordination and discharge planning must occur with the appropriate frequency to meet the client's individualized needs and should include providers that will be receiving the client upon discharge.
 - Continuation of ongoing ABA services that were provided in another setting prior to hospitalization does not meet criteria for expedited prior authorization (EPA).

Description of Service

Applied Behavior Analysis (ABA)

The Council of Autism Service Providers [CASP], (2020) provides the following description of ABA:

ABA is a scientific discipline among the helping professions that 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. Thus, when applied to ASD, ABA focuses on treating the problems of the disorder by altering the individual's social and learning environments. (p.4)

Coverage Rationale

Applied Behavior Analysis (ABA) is proven for the treatment of autism spectrum disorder in children when the following conditions are met:

- The intervention is a systematic approach, based on the principles of comprehensive applied behavior analysis;
- The intervention targets the core deficits of an autism spectrum disorder, as outlined by the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition, Text Revision (DSM-5-TR™), American Psychiatric Association (APA), 2022;
- The intervention is delivered in a home center/office or community setting as clinically indicated;
- The intervention is rendered directly by a Board-certified Behavior Analyst (BCBA), a licensed mental health clinician with additional documented training in applied behavior analysis, or a paraprofessional under the direct supervision of such professionals;
- The intervention is delivered with an appropriate level of intensity (e.g., per Behavior Analyst Certification Board® practice guidelines) and includes ongoing measurement of efficacy: the use of measurement tools and analysis of progress should be continuous, and treatment decisions based on objective analysis of assessment results;
- ABA is provided at the least restrictive and most clinically appropriate level to safely, effectively, and efficiently meet the needs of the individual. ABA is needed for reasons other than the convenience of the individual, family, physician, or other provider. ABA is not more costly than an alternative service, of which, are at least as likely to produce equivalent therapeutic results for the individual.

Many states have mandated coverage for treatment of autism spectrum disorder:

<http://www.asha.org/Advocacy/state/States-specific-Autism-Mandates/>

ABA is unproven for any of the following:

- Programs or interventions that do not meet all of the above proven conditions
- Programs that are not delivered by or under the supervision of an ABA-trained professional
- Programs that target mental disorders other than autism spectrum disorders as defined in the DSM-5-TR™
- Services that are otherwise covered under the Individuals with Disabilities Education Act (IDEA) are not covered (e.g., a 1:1 aid in the school setting). School ABA services do allow for coordination of services and would cover services such as, teacher training, meetings with school personnel, and observations in the school setting.
- According to a number of recent systematic reviews and meta-analyses, early intervention based on applied behavior analysis is associated with positive outcomes for children with autism spectrum disorder. Currently, there is insufficient evidence to determine which children are most likely to benefit (or not benefit) from specific interventions. Recent progress has been made in systematizing intervention approaches and measuring treatment fidelity.

- ABA treatment is well supported for children and adolescents up to the age of 21 for autism spectrum disorder. Interventions for young adult populations and diagnosis other than autism spectrum disorder remains limited. Treatment requests for adults will be clinically reviewed per the guidelines.

Utilization Management Criteria

Prior authorization is required for applied behavior analysis (ABA).

Diagnostic Evaluation

The diagnosis of autism spectrum disorder (ASD) must be validated by a documented comprehensive assessment demonstrating the presence of the following diagnostic criteria based on the DSM-5-TR™ (5th ed.; DSM-5-TR; APA,2022):

- Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following examples, currently or by history:
 - Deficits in social-emotional reciprocity, ranging 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.
 - Deficits in nonverbal communicative behaviors used for social interaction, ranging 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.
 - Deficits in developing, maintaining, and understanding relationships, ranging 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.
 - Symptoms that impair function are required to in order to be diagnosed with ASD (Hyman et al., 2020).

Specify current severity. See [TABLE A](#).

- Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following examples, currently or by history:
 - Stereotyped or repetitive motor movements, use of objects or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
 - 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).
 - 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).
 - Hyper- or hyporeactivity 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. See [TABLE A](#).

- Symptoms must be present in the early developmental period (but may not become fully manifested until social demands exceed limited capacities, or may be masked by learned strategies in later life).
- Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.
- 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.
- Intellectual disability without autism may be difficult to differentiate from autism in very young children. Individuals with intellectual disability who have not developed language or symbolic skills also present a challenge for differential diagnosis, since repetitive behavior often occurs in such individuals as well. A diagnosis of autism in an individual with intellectual disability is appropriate when social communication and interaction are significantly impaired relative to the developmental level of the individual's nonverbal skills (e.g., fine motor skills, nonverbal problem solving). In contrast, intellectual disability is the appropriate diagnosis when there is no apparent discrepancy between the level of social communicative skills and other intellectual skills.

As clinically indicated, the autism evaluation should include (Volkmar et al., 2014; Meyers & Johnson, 2007, reaffirmed 2014):

- The use of a standard parent- or clinician-rated screening instrument for autism, examples include, but not limited to (Volkmar et al., 2014):
 - Autism Behavior Checklist [ABC]
 - Childhood Autism Rating Scale [CARS]
 - Checklist for Autism in Toddlers [CHAT; M-CHAT]
 - Communication and Symbolic Behavior Scales Developmental Profile Infant-Toddler Checklist [CSBS-DP-IT-Checklist]
 - Autism Screening Questionnaire [ASQ]
 - Autism Quotient [AQ]
 - Childhood Autism Screening Test [CAST]
 - According to Adamou et al. (2021), assessment instruments such as the ADOS-2 should not be the definitive diagnostic tool for ASD. It is recommended that diagnoses are considered from an experienced multidisciplinary team with historical data, current observations, and qualitative information.
 - False-positive and false-negative results are of great concern when using a single diagnostic tool (Randall et al., 2018).
- The diagnosis of autism spectrum disorder (ASD), or other applicable diagnosis by state mandate, must be validated by a documented comprehensive assessment, completed by a licensed physician, psychologist, or other licensed clinician qualified to diagnose Autism by state licensure. The assessment must demonstrate the presence of the following diagnostic criteria based on the DSM-5-TR.
- Screening for autism spectrum disorder is recommended for all children at 18 and 24 month well-child visits (Hyman et al., 2020; MacDuffie et al., 2021).
- There is noteworthy evidence that screening as early as ages of 16-40 months in settings such as general pediatric practices yield positive predictive benefits, such as early initiation of services (Levy et al., 2020).
- An essential component of the diagnostic process is formal examinations of language, cognitive, and adaptive abilities and sensory status (Hyman et al., 2020).
- The use of a standard psychiatric assessment for autism, examples include (Volkmar et al., 2014):
 - Autism Diagnostic Interview-Revised [ADI]
 - Autism Diagnostic Observation Schedule [ADOS]
 - Diagnostic Interview for Social and Communication Disorders [DISCO].
- Observation tools used to confirm the ASD diagnosis include the Autism Diagnostic Observation Schedule, Second Edition (ADOS-2) and the Childhood Autism Rating Scale, Second Edition (CARS-2) (Hyman et al., 2020).
- Interviews with the child and family, and assessment of the parents' knowledge of autism spectrum disorder, coping skills, and available resources and supports (Volkmar et al., 2014).
- Review of past records (e.g., past and current behavioral interventions) and historical information (e.g., family history and relevant psychosocial issues) (Volkmar et al., 2014).
- A thorough history includes a long-term experience with the individual that demonstrates the effects of symptoms on the individual's ability to function various settings such as family, peer, and school (Hyman et al., 2020).
 - Questionnaires that establish a history of ASD symptoms and may be used as part of the complete evaluation are the Social Communication Questionnaire (SCQ) or the Social Responsiveness Scale (SRS) (Hyman et al., 2020).
- As clinically appropriate, systematic attention to the areas relevant to differential diagnosis with specific attention to as to whether social communication skills fall below the individual's developmental level, including (*Diagnostic and Statistical Manual of Mental Disorders* 5th ed -TR.; DSM-5-TR; APA, 2022):
 - Rett syndrome
 - Selective mutism
 - Language disorders and social (pragmatic) communication disorder
 - Intellectual disability (intellectual developmental disorder) without autism spectrum disorder
 - Stereotypic movement disorder
 - Attention-deficit/hyperactivity disorder
 - Schizophrenia
- Assessment of co-occurring developmental conditions should include (Hyman et al., 2020):

- Cognitive Testing
- Adaptive Function Testing
- Sensory Assessments: Hearing, Vision, Sensory Processing
- As clinically appropriate, attention to possible comorbid diagnoses (Hyman et al., 2020);
- Observation of broad areas of social interaction that include restricted and repetitive patterns of behavior that cause substantial impairment in numerous functional aspects (Pinals et al., 2022);
- When clinically appropriate, a medical assessment, including physical examination, hearing screen, and examination for signs of other genetic abnormalities (Volkmar et al., 2014);
- Identifying the genetic aspect of ASD via genetic testing provides clinicians with additional data for families about prognosis and recurrence risk (Hyman et al., 2020);
- When clinically appropriate, psychological assessment, such as:
 - Measurements of cognitive ability and adaptive skills
 - Use of standard tests of intelligence
 - Identification of areas of strength and weakness useful for designing intervention programs
- When clinically appropriate communication assessment, such as measurement of receptive and expressive vocabulary and language use or a summary of the individual's use of language in everyday situations (Volkmar et al., 2014).
- When members of multiple disciplines engage in assessment (e.g., occupational therapy, physical therapy), coordination among the various professionals is required (Volkmar et al., 2014).

Treatment Planning

Once an ASD diagnosis has been established:

- A standardized functional assessment is used to maximize the effectiveness and efficiency of behavioral support interventions (Myers & Johnson, reaffirmed 2014).
 - The assessment may incorporate information such as interviews with caregivers, structured rating scales, direct observation data, and attention to coexisting medical conditions (Kurtz et al., 2020; Myers & Johnson, reaffirmed 2014).
 - The assessment should include baseline data and inform subsequent establishment of treatment goals (The Council of Autism Service Providers [CASP], 2020).
- ABA services do not duplicate service provided to or available to the individual by other medical or behavioral health services. Examples include, but are not limited to, behavioral health treatment such as individual, group, and family therapies, occupational therapy, speech therapy.
- When an individual displays maladaptive behavior it is recommended the credentialed provider complete a functional behavior assessment to better inform treatment planning (CASP, 2020; Kurtz et al., 2020).
 - Information from the functional assessment is incorporated into the behavior treatment plan. A functional analysis may be necessary if the likely reasons for a problem behavior were not identified via a functional assessment (CASP, 2020).
- Targets include areas such as the following (CASP, 2020):
 - Social communication skills and focus on the social importance of the behaviors targeted
 - Social language skills
 - Social interaction skills
 - Restricted, repetitive patterns of behavior, interests, or activities
 - Self-injurious, violent, destructive or other maladaptive behavior
 - Replacement skills for problem behaviors.
- A credentialed provider with ABA expertise is identified to provide treatment. Examples include (CASP, 2020):
 - A Master- or Doctoral-level provider that is a Board-Certified Behavior Analyst (BCBA)
 - A licensed behavioral health clinician who has attested to having sufficient expertise and has been credentialed to provide ABA services
 - Behavior Analysts can carry caseloads that allow them to provide appropriate case supervision across cases. Caseload size may be influenced by the complexity of clients, treatment hours clients are receiving, and availability of support staff

- A Board-Certified Assistant Behavior Analyst (BCaBA) or non-licensed individual under the direct supervision of a BCBA or licensed behavioral health clinician who takes responsibility for the member's care that does either of the following:
 - Assist in the initial or concurrent assessment of the member's deficits or adaptive behaviors
 - Implement a treatment plan that has been developed by a BCBA or licensed behavioral health clinician
- Supervision is responsive to individual client needs. Two hours for every ten hours of direct treatment is the general standard of care. Other factors may increase or decrease case supervision, such as barriers to progress, issues of client health and safety, and transitions with implications for continuity of care (CASP, 2020).
- Direct supervision time may account for 50 percent or more of case supervision time, with the remaining time utilized in indirect supervisory activities such as treatment planning (CASP, 2020).
- Outcome-oriented interventions targeting specific baseline behaviors are identified in a treatment plan describing the frequency, intensity, duration and progress that will be continuously updated (CASP, 2020):
 - Treatment planning is considered a necessary part of ongoing ABA treatment and should be completed as clinical indicated.
 - The treatment plan must address how the parents/guardians will be trained in management skills that can be generalized to the home.
 - As clinically indicated, parent/guardian training is an expectation. In the rare circumstance that parent/guardian is unable the documentation must reflect the reason and identify an alternate plan to provide management skills in the home.
 - The treatment goals and objectives must be comprehensive and clearly stated.
 - Direct support and training of family members and other professionals promotes optimal functioning and generalization and maintenance of behavioral improvements (CASP, 2020).
 - The treatment plan is coordinated with other professionals to ensure appropriate client progress this may include coordination with the school and applicable IFSP/IEP, outpatient behavioral clinicians, medical doctors, speech/occupational therapists and others (CASP, 2020).
- Overall, the available clinical evidence reveals that the younger the age at treatment induction is associated with superior outcomes (Wolff & Piven, 2021).
- All components of the child's care are tracked and updated throughout the duration of services (CASP, 2020).

Treatment

ABA intervention must include the following elements (CASP, 2020; Myers & Johnson, 2014; Volkmar et al., 2014):

- Mitigate the core features of ASD
- ABA is an intensive treatment
- Target specific deficits related to imitation, attention, motivation, compliance and initiation of interaction, and the specific behaviors that are to be incrementally taught and positively reinforced tie to objective and quantifiable treatment goals that have baseline data, measurable progress, and projected timeframes for completion. Include the child's parents in parent training and the acquisition of skills in behavior modification to promote management of skills within the home
- Treatment plans are usually reviewed/updated twice annually, as appropriate per state mandate and/or clinical presentation of individual. This allows for ongoing re-assessment and documentation of treatment progress
- Treatment goals are prioritized in to address behaviors that threaten the health or safety of the client or others or create a barrier to quality of life. Goals are also prioritized to increase skills fundamental to maintaining health and social inclusion
- Descriptions of any needed replacement behaviors and skill acquisition goals based on the reported behaviors and assessments
- Train family members and other caregivers to manage problem behavior and interact with the child in a therapeutic manner
- As indicated, include psychotherapy (e.g., cognitive behavioral therapy) for higher functioning children to treat conditions such as anxiety and anger management
 - Have an appropriate level of intensity and duration driven by factors such as:

- Treatment plan should indicate the treatment setting, instructional methods to be used, hours requested and clinical justification of those hours
 - Changes in the targeted behavior(s) / response to treatment
 - The demonstration and maintenance of management skills by the parents and caregivers
 - Whether specific issues are being treated in a less intensive group format (e.g., social skills groups)
 - The child's ability to participate in ABA given attendance at school, daycare or other treatment settings
 - The impact of co-occurring behavioral or medical conditions on skill attainment
 - The member's overall symptom severity; and
 - The member's progress in treatment related to treatment duration.
- o When group ABA services are included, the treatment plan must include clearly defined, measurable goals for the group therapy that are specific to the individual's needs.
 - o According to Rogers et al. (2021) there is a lack of high quality clinical evidence to suggest that a higher number of hours results in improved outcomes for children, including those children with substantial difficulties.
 - o According to Lotfizadeh et al. (2020) there is limited evidence to show those individuals receiving very low intensity services make as much progress as those receiving a higher volume of hours.
- Treatment methodologies utilized as part of intensive behavior therapies should be considered established by the National Autism Centers Standards Projects.
 - Parent/Caregiver support is expected to be a component of the ABA program, as they will need to provide additional hours of behavioral interventions. Parents or caregivers must be involved and engaged in the training and follow through on treatment recommendations beyond that provided by licensed or certified practitioners. Caregivers are engaged to assist with maintenance and generalization of skills and to focus on activities of daily living (Myers & Johnson, 2014). Parent support groups are considered not medically necessary.
 - Parent and caregiver training include a systematic, individualized curriculum on ABA fundamental concepts. The goal of this training is skills development and support so that parents and caregivers are proficient in implementing treatment strategies in a variety of settings and critical environments (CASP, 2020).
 - ABA programs typically fall into either focused or comprehensive ABA treatment. The type of treatment may lend itself to different intensity of services. Total intensity of services includes both direct and indirect services (e.g. caregiver training and supervision). Hours may be increased or decreased based on the client's response to treatment and current needs. Comprehensive services are typically rendered when the individual is early in his or her development. These services are not intended to be applied to older children or adolescents who are often more appropriate for focused intervention. Comprehensive services commonly focus on most areas of functioning and are intended to improve multiple skills. Focused intervention is intended to reduce dangerous or maladaptive behavior and strengthen more appropriate functional behavior (CASP, 2020).
 - When adolescents and young adults are receiving ABA services, it is important to include a focus on transition to adulthood. Including ensuring goals focus on steps to independence, are patient centered, and include caregivers (when appropriate) in creating a plan (Powell et al., 2021; White et al., 2018).
 - According to Bahry et al. (2022), supporting individuals with ASD across the lifespan includes ethical considerations. Behavior analysts should consider prioritizing skills with meaningful current and future outcomes for individuals transitioning into adulthood.
 - These steps can increase the number of adolescents with ASD who receive recommended transition to adulthood planning (National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention, 2022):
 - o Healthcare providers consider recommendations for healthcare transitioning and use them when providing care for adolescents, beginning at age 12 years, and modifying to meet the unique needs of each adolescent.
 - o Parents can address transition planning with their child's pediatric healthcare providers.
 - o Healthcare professionals can utilize strategies for moderating gaps in health service utilization by:
 - Providing interdisciplinary training to professionals that endorses the programs with positive outcomes and increases provider confidence in treating adolescents with ASD and other developmental disorders;
 - Improving multidisciplinary care delivery services to be timely, coordinated, and family-centered; and
 - Promoting programs with successful healthcare transitions for adolescents, including those with ASD and other developmental disorders.

Coordination of Care

If applicable, documentation of communication and coordination with other service providers and agencies, (i.e. day care, preschool, school, early intervention services providers) and/or other allied health care providers (i.e. occupational therapy, speech therapy, physical therapy and any other applicable providers) to reduce the likelihood of unnecessary duplication of services. According to the CASP (2020) collaborating between all professionals engaged with a child will ensure consistency, as better consistency leads to better outcomes. Documentation should include the following:

- Types of therapy provided
- Number of therapies per week
- Behaviors/deficits targeted
- Progress related to the treatment/services being provided
- Measurable criteria for completing treatment with projected plan for continued care after discharge from ABA therapy
- Total number of days per week and hours per day of direct services to child and parents or caregivers to include duration and location of requested ABA therapy
- Dates of service requested
- Licensure, certification and credentials of the professionals providing ABA services to the child
- Evidence that parents and/or caregivers have remained engaged in the treatment plan, following all appropriate treatment recommendations
 - Detailed description of interventions with the parent(s) or caregiver(s), including:
 - Parental or caregiver education, training, coaching and support
 - Overall parent or caregiver goals including a brief summary of progress. As part of the summary of progress the information should also include percentage of planned sessions attended
 - Plan for transitioning ABA interventions identified for the child to the parents or caregivers.

Continued Treatment

With each medical necessity review for continued ABA treatment, an updated treatment plan and progress reports will be required for review, including all of the following documentation (CASP, 2020; Myers & Johnson, 2014; Volkmar et al., 2014):

- There is a reasonable expectation on the part of the treating clinician that the child's behavior and skill deficits will continue to improve to a clinically meaningful extent, in at least two settings (home, school, community) with ABA services
- Therapy is not making the symptoms or behaviors persistently worse
- Progress is assessed and documented for each targeted symptom and behavior, including progress toward defined goals, and including the same modes of measurement that were utilized for baseline measurements of specific symptoms and behaviors
- The treatment plan and progress report should reflect improvement from baseline in skill deficits and problematic behaviors using validated assessments of adaptive functioning
- Parent/Caregivers are involved and making progress in their own development of behavioral interventions
- The treatment plan should reflect a plan to transition services in intensity over time
- When there has been inadequate progress with targeted symptoms or behaviors, or no demonstrable progress within a 6 month period, or specific goals have not been achieved within the estimated timeframes, there should be an assessment of the reasons for inadequate progress or not meeting the goals, and treatment interventions should be modified or changed in order to attempt to achieve adequate progress. Documentation of such an assessment and subsequent treatment plan change(s) must include:
 - Increased time and/or frequency working on targets
 - Change in treatment techniques
 - Increased parent/caregiver training
 - Identification and resolution of barriers to treatment effectiveness
 - Any newly identified co-existing disorder (e.g., anxiety, psychotic disorder, mood disorder)
 - Goals reconsidered (e.g., modified or removed)
- According to Rogers et al. (2021) predicting outcomes for young children is difficult because children receiving early treatment can change dramatically over time. Future outcomes are better predicted when measuring continued treatment progress after a few years, rather than when receiving the initial diagnosis.

- When goals have been achieved, either new goals should be identified that are based on targeted symptoms and behaviors that are preventing the child from adequately participating in age-appropriate home, school or community activities, or that are presenting a safety risk to self, others, or property; or the treatment plan should be revised to include a transition to less intensive interventions.
- Treatment methodologies utilized as part of intensive behavior therapies should be considered established by the National Autism Centers Standards Projects.

Discharge

When any of the following criteria are met the child will be considered discharged and any further ABA services will not be covered (CASP, 2020):

- Documentation that the child demonstrates improvement from baseline in targeted skill deficits and behaviors to the extent that goals are achieved, or maximum benefit has been reached
- Documentation that there has been no clinically significant progress or measurable improvement for a period of at least 3 months in the child's behaviors or skill deficits in any of the following measures:
 - Adaptive functioning
 - Communication skills
 - Language skills
 - Social skills
- The treatment is making the skill deficits and/or behaviors persistently worse
- The child is unlikely to continue to benefit or maintain long term gains from continued ABA therapy
- Parents and/or caregivers have refused treatment recommendations or are unable to participate in the treatment program and/or do not follow through on treatment recommendations to an extent that compromises the effectiveness of the services.

Documentation Requirements

ABA providers are required to have a separate record for each member that contains the following documentation:

- Comprehensive assessment establishing the autism diagnosis
- All necessary demographic information
- Complete developmental history and educational assessment
- Functional behavioral assessment including assessment of targeted risk behaviors
- Behavioral/medical health treatment history including but not limited to:
 - known conditions
 - dates and providers of previous treatment
 - current treating clinicians
 - current therapeutic interventions and responses
- Individualized treatment plan and all revisions to the treatment plan, including objective and measurable goals, as well as parent training, barriers to progress, response to interventions
- Daily progress notes including:
 - place of service
 - start and stop time
 - who rendered the service
 - the specific service (e.g., parenting training, supervision, direct service)
 - who attended the session
 - interventions that occurred during the session
- All documentation must be legible
- All documentation related to coordination of care; including with school related services rendered via an IEP. Attempts to coordinate care is acceptable if other providers will not collaborate
- All documentation related to supervision of paraprofessionals
- If applicable and available, a copy of the child's Individualized Education Plan (IEP)

- If applicable and available, progress notes related to Early Intervention Plan or Pre-school/Special Education Program or allied health services
- Certification and credentials of the professionals providing the ABA therapy.

Table A

Severity Levels for Autism Spectrum Disorder

<i>Severity Level</i>	<i>Social Communication</i>	<i>Restricted, Repetitive Behaviors</i>
<i>Level 3 –Requiring very substantial support</i>	<i>Severe deficits in verbal and nonverbal social communication skills causes 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.</i>	<i>Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interferes with functioning in all spheres. Great distress/difficulty in changing focus or action.</i>
<i>Level 2 –Requiring substantial support</i>	<i>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.</i>	<i>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.</i>
<i>Level 1 –Requiring support</i>	<i>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.</i>	<i>Inflexibility of behavior causes significant interference with functioning in or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.</i>

Source: American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders, (5th ed.)*, Text Revision. Table 2. American Psychiatric Publishing.

Diagnosis Codes

The following list(s) of diagnosis code(s) is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member-specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other clinical criteria may apply.

Diagnosis Codes	Description
F84.0	Autistic Disorder

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Revision History

Date	Summary of Changes
03/16/2020	Version 1; Supplemental Clinical Criteria
03/15/2021	Annual Review
04/19/2021	Interim Update: Added New Jersey state mandates information
06/21/2021	Interim Update: Removed AZ state mandate information
09/21/2021	Interim Update: Added Massachusetts, New York, Washington information to the State Mandates section
04/19/2022	Annual Review: Added Pennsylvania information, sources updated.
06/21/2022	Interim Update: Added Virginia information to the State Mandates section
08/23/2022	Interim Update: Added California and revised Maryland in State Mandates section
10/18/2022	Interim Update: Update to NY guidance in State Mandates section
12/22/2022	Interim Update: Update to State Mandates section
01/17/2023	Interim Update: Update to State Mandates section

Date	Summary of Changes
04/18/2023	Annual Review
08/22/2023	Interim Review: Update to State Mandates section
09/19/2023	Interim Review: Removal of Applicable Codes section
10/17/2023	Interim Review: Update to State Mandates section
12/12/2023	Interim Review: Update to State Mandates section

Appendix

Additional resources considered in support of this document:

Hayes, Inc. (2019). Comparative Effectiveness Review of Intensive Behavioral Intervention for Treatment of Autism Spectrum Disorder. Lansdale, PA. Updated March 2019.