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

Initiation of ABA-based therapy may be considered medically necessary when ALL of the following criteria are met:

A. The member has a diagnosis of an Autism Spectrum Disorder (DSM-IV-TR}
299.0; 299.10; 299.80; DSM 5 299.00 or effective October 1, 2015, ICD-10 F84.0, F84.5, or F84.9) by a Licensed Provider experienced in the diagnosis and treatment of autism. In addition, for applicable member contracts in Oregon, Utah, and Washington, the diagnosis has been validated by a documented comprehensive assessment demonstrating that any of the following is met:

1. For member contracts subject to Oregon’s Mental Health Parity Act (ORS 743.168) or Washington’s Mental Health Parity Act (RCW 48.44), DSM-5 diagnostic criteria have been met if the diagnosis was made after the release of DSM-5 or DSM-IV diagnostic criteria have been met if the diagnosis was made prior to the release of DSM-5; OR

2. For member contracts subject to Utah’s Autism Services Amendment SB 57 (UCA 31A-22-642), diagnostic criteria have been met as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

B. 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

C. ABA therapy must be recommended or prescribed by a Licensed Provider experienced in the diagnosis and treatment of autism and such Provider shall determine and document the target symptoms and objectives of the therapy; and

D. Based upon the recommendation or prescription from the Prescribing Provider, which includes the target symptoms and objectives of the therapy, a documented individualized treatment plan (ITP) is prepared by the Prescribing Provider or a qualified Lead Behavior Analysis Therapist (LBAT) within 90 days before beginning ABA. An ITP prepared by an LBAT shall be documented in the medical record and reviewed by the Prescribing Provider before implementation; and

E. The individualized treatment plan (ITP) shall include ALL of the following:

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 and the documentation related to that therapy is available to the LBAT, a description of the prior treatment interventions and techniques, the goals of treatment, whether the goals were achieved, and the rationale for additional course of ABA therapy; and
5. Specific treatment goals for each targeted behavior, including all of the following:
   a. Goals can be generalized outside the treatment setting; and
   b. Objective measures; and
   c. Time-based milestones.

6. A description of training and participation of family (parents, legal guardians and/or active caretakers as appropriate) in achieving treatment goals, including detailed description of interventions with family, including, as appropriate, family education, support, training, overall goals for the family, and plan for transferring to the family the interventions with member; and

7. The total number of days per week and hours per day of direct ABA services to the member and of services to the family, and the hours per week of direct face-to-face supervision of the treatment being delivered and observation of the child in his/her natural setting; and

8. Measurable discharge and/or transition criteria.

II. Continuation of ABA-based Therapy

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 are met:

A. 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 LBAT collates and evaluates the data from all sessions and conducts a case review and treatment plan review at least once per month. Such LBAT review shall include in-person and direct observation of the patient; and

B. Member clinical response to treatment is monitored and treatment is provided according to the ITP and member clinical response; 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. There is objective evidence of continued improvement in at least one of the core functional areas of communication, social interaction or adaptive behavior, as measured by the indices established in the ITP; and

E. At least every three months, the LBAT has assessed the member and updated the ITP as indicated by the member’s response to therapy and obtained review by the Prescribing Provider or another licensed provider who has experience in the diagnosis and treatment of autism; and

F. Intervals at which progress towards goals will be evaluated: objective measurements and evaluation to occur at least every three to twelve months.

III. Initial or continued ABA-based therapy for all indications, including but not limited to
treatment of autism spectrum disorders, 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

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

INITIAL PRE-AUTHORIZATION

- Documentation of the following from the prescribing provider (criteria IA-IB 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 prescribing provider which contains the target symptoms and objectives of therapy (criteria IC above)
- Individualized treatment plan (ITP) with the information listed in criteria IE1-IE8 above including documentation that the ITP was sent to the prescribing provider
- List of specific services requested with the number of units/hours requested per specified time period

CONTINUATION OF ABA-BASED THERAPY

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 IIA-IIF above including documentation that the ITP was sent to the prescribing provider

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
- Utah’s Autism Services Amendment, SB 57 (UCA 31A-22-642) effective 2016.

CROSS REFERENCES

None

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, 4th Edition[1], Text Revision (DSM-IV-TR), ASD includes:

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

Diagnostic criteria for ASD as defined by the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)[2], 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.”

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).

REFERENCES


CODES

<table>
<thead>
<tr>
<th>Codes</th>
<th>Number</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>CPT</td>
<td>0359T</td>
<td>Behavior identification assessment, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes</td>
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</tbody>
</table>
Codes   Number   Description

administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report

0360T  Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-to-face with the patient

0361T  each additional 30 minutes of technician time, face-to-face with the patient (List separately in addition to code for primary service)

0362T  Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or 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

0363T  each additional 30 minutes of technician(s) time, face-to-face with the patient (List separately in addition to code for primary procedure)

0364T  Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; first 30 minutes of technician time

0365T  each additional 30 minutes of technician time (List separately in addition to code for primary procedure)

0366T  Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time

0367T  each additional 30 minutes of technician time (List separately in addition to code for primary procedure)

0368T  Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; first 30 minutes of patient face-to-face time

0369T  each additional 30 minutes of patient face-to-face time (List separately in addition to code for primary procedure)

0370T  Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)

0371T  Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)

0372T  Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face-to-face with multiple patients

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

0374T  each additional 30 minutes of technicians' time face-to-face with patient (List separately in addition to code for primary procedure)

HCPCS  H2020  Therapeutic behavioral services, per diem

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):

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).
APPENDIX 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).

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

<table>
<thead>
<tr>
<th>Severity level</th>
<th>Social communication</th>
<th>Restricted, repetitive behaviors</th>
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</thead>
<tbody>
<tr>
<td>Level 3 “Requiring very substantial support”</td>
<td>Severe deficits in verbal and nonverbal social communication skills cause severe impairment 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.</td>
<td>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.</td>
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<tr>
<td>Level 2 “Requiring substantial support”</td>
<td>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.</td>
<td>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.</td>
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</table>
**APPENDIX 1**

<table>
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<tr>
<th>Level 1</th>
<th>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.</th>
</tr>
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<tbody>
<tr>
<td>“Requiring support”</td>
<td>Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.</td>
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</tbody>
</table>

*Date of Origin: January 2012*