Clinical Policy: Applied Behavioral Analysis

Reference Number: WA.CP.MP.104 Coding Implications
Last Review Date: 08/19 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Applied Behavioral Analysis (ABA) is the application of behavioral principles to everyday situations, intended to increase or decrease targeted behaviors. ABA has been used to improve areas such as language, self-help, and play skills, as well as decrease behaviors such as aggression, self-stimulatory behaviors, and self-injury. For those with autism spectrum disorder (ASD), treatment may vary in terms of intensity and duration, complexity and treatment goals, and the extent of treatment provided characterized as focused or comprehensive. Focused ABA is direct care provided for a limited number of behavioral targets. It is appropriate for those who need treatment only for a limited number of key functional skills or have such acute problem behavior that its treatment should be the priority. Comprehensive ABA is for treatment of multiple affected developmental domains, such as cognitive, communicative, social, emotional, and adaptive functioning. It ranges from 25 - 40 hours of treatment per week (plus direct and indirect supervision and caregiver training)[16] to increase the potential for behavior improvement. ABA can also be referred to as Lovaas therapy and intensive behavioral intervention (IBI).

Policy/Criteria
Initial Request

I. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority's Health Technology Assessment and billing guideline, that when ABA is a covered benefit, the initiation of services is considered **medically necessary** for members meeting all of the following criteria:
- A. The Required Documentation has been submitted, and
- B. The member meets all of the severity of illness criteria
  - **A.** Member is age twenty or younger. The day treatment program is restricted to age two through five and
  - **B.** The member has one of the following
    - a. the Diagnostic Statistical Manual (DSM) or
    - b. A developmental disability for which there is evidence ABA services are effective and
- C. Member exhibits functional impairment, communication delays, social interactions, repetitive, stereotyped behavior or severe behavior that presents a clinically significant health or safety risk to self or others (such as self-injury, aggression toward others, and destruction of property, elopement, severe disruptive behavior or significant interference with basic home or community activities of daily life) and
- D. Less-intensive behavior treatment or other therapy of 60-90 days in duration has not been sufficient to reduce interfering behaviors, to increase pro-social behaviors, or to maintain desired behaviors and

E. An appropriate diagnostician has ruled out all of the following as a sole explanation for symptoms of autism spectrum disorder:
   - Neurological disorder (by an MD)
   - Lead poisoning (by an MD)
   - Primary speech disorder
   - Primary hearing disorder and

F. The requesting provider is either from a Center of Excellence (COE) or Applied Behavior Analysis (ABA) therapy service provider and

G. The COE or medical provider completes a comprehensive diagnostic evaluation that indicates evidence-based ABA services are medically necessary. The evaluation should include all of the following, but is not limited to:
   1. A clinical history with informed parent/guardian, inclusive of developmental and psychosocial history
   2. Direct observation
   3. Review of available records and standardized measures including ASD core features, general psychopathology, cognitive abilities, and adaptive functioning using published instruments administered by qualified members of a diagnostic team and

H. The member is medically stable and does not require 24-hour medical/nursing monitoring or procedures provided in a hospital level of care and

I. There is a reasonable expectation on the part of a qualified treating health care professional who has completed an initial evaluation of the member that the individual's behavior will improve significantly with ABA therapy provided by, or supervised by, a credentialed and contracted ABA provider and

J. The treatment plan is built upon individualized age and functionally appropriate goals and projected time lines to achieve those goals. Objectives are measurable and tailored to the patient and

K. Parent or caregiver training and support is incorporated into the treatment plan and takes place on a regular basis and

L. Interventions are consistent with ABA techniques and emphasize generalization of skills and focus on the development of spontaneous social communication, adaptive skill, and appropriate behaviors and

M. The number of service hours necessary to effectively address the challenging behaviors is listed in the treatment plan and

N. ABA services are provided by appropriate professionals or paraprofessionals meeting their individual state requirements as appropriately licensed, certified or otherwise approved to provide ABA evaluations, assessments, care/treatment planning and the delivery of the recommended services.

Recertification of Services

II. When ABA is a covered benefit, the recertification pf services is considered **medically necessary** for members meeting all of the following criteria:

A. The Required Documentation has been submitted, and

B. The request is received at least 5 days before the expiration of the last authorization, and

C. There is reasonable expectation the member will benefit from the recertification of ABA therapy as evidenced by mastery of skills define din the initial plan or a change of treatment approach from the initial plan, and

D. Measurable progress is documented. Continued progress is determined based on improvement in goals as outlined in the provider treatment plan and will focus on improvements in verbal skills, social functioning and IQ (for children under 4 years), and
E. Treatment is not making the symptoms worse, and
F. There is reasonable expectation, based on the member's clinical history that withdrawal of treatment will result in decompensation or recurrence of signs and symptoms.

III. ABA therapy is **Not Covered** for any of the following:
A. Speech therapy
B. Occupational therapy
C. Vocational rehabilitation
D. Supportive respite care
E. Recreational therapy
F. Orientation and mobility
G. ABA services provided in the school setting
H. Services provided in duplicate through any other source/setting

Transition/Discharge Planning

IV. Members may reduce or end ABA services after achieving their treatment goals. Upon successfully meeting treatment goals, members may better qualify for lower levels of care. This can be demonstrated by the following:
- Member's and family's ability to generalize the skills in multiple settings and mastery of the majority of the program goals.
- Step-down in program hours as recommended by the provider.
- Member's readiness to move from current level of service to lower level of service.
- Communication and coordination of care between all other professionals involved in member's care.

Termination/Denial of Services

V. Medical necessity denial of services may be due to any one of the following:
A. No meaningful, measurable change has been documented in the patient's behavior(s) for a period of three to six months or optimal treatment. For changes to be "meaningful" they must be durable over time beyond the end of the actual treatment session and generalized outside of the treatment setting to the patient's residence and to the larger community within which the patient resides.
B. Treatment is making the symptoms worse
C. The patient has achieved adequate stabilization of the challenging behavior and less-intensive modes of therapy are appropriate
D. The patient demonstrates an inability to maintain long-term gains from the proposed plan of treatment
E. Noncompliance – does not keep appointments, parent fails to attend treatment sessions and/or fails to attend scheduled parent training sessions.

Required Documentation

I. Initial Request
- **A.** Applied Behavioral Analysis Outpatient Treatment Form (filled out completely and legible).
- **B.** Doctor's order for ABA services and Autism Spectrum Disorder diagnosis or other developmental disorder that would benefit from ABA therapy.
- **C.** Comprehensive Diagnostic Evaluation for Autism (as defined by WAC 182-531A-0500) by a Center of Excellence (COE)
- **D.** Autism Spectrum Disorder DSM-5 Checklist
- **E.** HCA Applied Behavioral Analysis (ABA) Level of Support Checklist
- **F.** Up-to-date treatment plan with SMART goals.

II. Recertification
- **A.** Documentation of actual services received
- **B.** Graphic representation of progress made by the member
- **C.** Updated treatment plan showing updates at a minimum every 30 days.

Background

A number of scientific studies have been conducted evaluating the effectiveness of ABA. The original and long-term follow-up study conducted by O. Ivar Lovaas included 38 children who were non-randomly assigned to ABA therapy or minimal therapy. Outcomes were compared to data from 21 children in another facility that had similar characteristics. Lovaas reported improvements in cognitive function and behavior that were sustained for at least 5 years. Almost half of the ABA group passed normal first grade and had an IQ score that was at least average. The flaws in this study included: small sample size, non-randomization of patients to treatment groups, potential selection bias, and endpoints that may not meet current standards (Hayes Medical Directory). More recent studies have reported effectiveness in some autistic children, especially in relatively high-functioning children, but none have replicated the results from the Lovaas study.

Multiple systematic reviews with meta-analyses have been conducted on ABA studies for ASD, with conflicting results. Ospina and colleagues (2008) systematically reviewed studies comparing behavioral and developmental interventions for ASD. The four randomized control trials (RCTs) reviewed that compared ABA to Developmental Individual-difference relationship-based intervention (DIR) or Integrative/Discrete trial combined with Treatment and Education of Autistic and related Communication Handicapped Children (TEACCH) found no significant difference in outcomes (Ospina et al., p. 4). Seven out of eight studies that reported significant improvements were not RCTs and have significant methodological limitations (Ospina et al., 2008, p. 5). Results from a meta-analysis of controlled clinical trials demonstrated that Lovaas is superior to special education for a variety of outcomes; however, there is no definitive evidence suggesting superiority of Lovaas over other active interventions (Ospina et al. 2008, p. 26). Additionally, five other systematic reviews found that ABA was an effective intervention for ASD, but still noted the substantial limitations of included studies, which could affect meta-

analysis results and the expected efficacy of ABA (Eldevik 2009; Reichow 2009; Makrygianni 2010; Virues-Ortega 2010; Warren et al. 2011).

Furthermore, Reichow and others (2014) conducted a systematic review of the RCTs, quasi-RCTs, and controlled clinical trials in the ABA literature, commenting that these were not of optimal design. Reichow and others (2014) concluded that the evidence suggests ABA can lead to improvements in IQ, adaptive behavior, socialization, communication and daily living skills. However, they strongly caution that given the limited amount of reliable evidence, decisions about using ABA as an intervention for ASD should be made on a case by case basis (Reichow et al. 2014, p. 33). In contrast, Spreckley and Boyd (2009) state in their systematic review that children receiving high intensity ABA did not show significant improvement in cognitive functioning (IQ), receptive and expressive language, and adaptive behavior compared to lesser interventions including parenting training, parent- applied behavior intervention supervised weekly by a therapist, or interventions in the kindergarten.

Further research needs to be done to determine the effectiveness of ABA at improving IQ, language skills, social skills, and adaptive behaviors, especially compared to other interventions. In addition, rigorous studies should examine which subgroups of children or adolescents with ASD benefit the most from ABA.

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
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

CPT®* Codes	Description
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes
0362T	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; 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

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
F84.0	Autistic disorder
F84.2	Rett's syndrome
F84.3	Other childhood disintegrative disorder
F84.5	Asperger's syndrome
F84.8	Other pervasive developmental disorders
F84.9	Pervasive developmental disorder, unspecified

Reviews, Revisions, and Approvals	Date	Approval Date
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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.