Clinical Policy: Applied Behavior Analysis

Reference Number: WA.CP.BH.104
Date of Last Revision: 09/25
Effective Date: 11/01/25

Coding Implications
Revision Log

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

Description

Autism spectrum disorder (ASD) is a neurodevelopmental disorder characterized by varying degrees of difficulty in social communication and interaction. ASD is typically a lifelong diagnosis, and the variability of symptom presentation differs for everyone, requiring treatment at any point in time.[1]

Applied Behavioral Analysis (ABA) is the application of behavioral principles to everyday situations, intended to increase skills 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. Treatment may vary in terms of intensity and duration, complexity, and treatment goals. The extent of treatment provided can be characterized as focused or comprehensive.[1]

Coordinated Care of Washington, Inc., will collaborate with providers to implement best practices and standardization of outcome measures into the Applied Behavior Analysis treatment plan.

Policy/Criteria

I. It is the policy of Coordinated Care of Washington, Inc., that ***initial*** *Applied Behavior Analysis (ABA) services* are **medically necessary** when meeting all the following:
   A. The member/enrollee has a comprehensive diagnostic evaluation and multidisciplinary clinical treatment plan completed by a Health Care Authority (HCA) recognized ABA Center of Excellence (COE). The evaluation establishes all of the following:
      1. The presence of functional impairment; delay in communication, behavior, or social interaction; or repetitive or stereotyped behavior,
      2. The impairment, delay, or behaviors adversely affect development or communication or both, such that:
         a. The member/enrollee cannot adequately participate in home, school, or community activities because of the behavior or skill deficit interferes with these activities, or
         b. The behavior endangers the member/enrollee or another person, or impedes access to home and community activities
      3. A confirmed autism spectrum disorder (ASD) diagnosis or other intellectual/developmental disability for which there is evidence ABA is effective.
      4. There is a reasonable expectation that the requested services will result in measurable improvement in either the member/enrollee's behavior, skills, or both,
      5. One of the following:
         a. Less intrusive or less intensive behavioral interventions have been tried and have not been successful, or

b. No equally effective and substantially less costly alternative is available for reducing interfering behaviors, increasing prosocial skills and behaviors, or maintaining desired behaviors.

B. The member/enrollee has an ABA Assessment and Behavior Change Plan form (HCA 13-400) completed by a Lead Behavioral Analysis Therapist (LBAT). The treatment plan must:
   1. Be applicable to the services to be rendered over the next six months and correlate with the COE's diagnostic evaluation.
   2. Address each behavior, skill deficit, and symptom that prevents the member/enrollee from adequately participating in home, school, employment, community activities, or that presents a safety risk to the member/enrollee or others,
   3. Be individualized,
   4. Be member-centered, family-focused, community-based, culturally competent, and minimally intrusive,
   5. Take into account all school or other community resources available to the client, confirm that the requested services are not redundant or in conflict with, but are in coordination with, other services already being provided or otherwise available, and coordinated services with other interventions and treatments,
   6. Focus on family engagement and training,
   7. Identify and describe in detail the targeted behaviors and symptoms,
   8. Include objective, baseline measurement levels for each target behavior/symptom in terms of frequency, intensity, and duration, including use of curriculum-based measures, single-case studies, or other generally accepted assessment tools,
   9. Include a comprehensive description of treatment interventions, or type of treatment interventions and techniques specific to each of the targeted behaviors/symptoms, including documentation of the number of service hours, in terms of frequency and duration, for each intervention,
   10. Establish treatment goals and objective measures of progress for each intervention specified to be accomplished in the authorized treatment period,
   11. Incorporate strategies for promoting the learning of skills that improve targeted behaviors within settings,
   12. Integrate family education, goals, training, support services, and modeling and coaching family/member interaction,
   13. Incorporate strategies for coordinating treatment with school-based education and vocational programs, behavioral health treatment, habilitative supports, and community-based early intervention programs, and plan for transition through a continuum of treatments, services, and settings,
   14. Include measurable discharge criteria and a discharge plan.

C. The member/enrollee has an Applied Behavior Analysis Level of Support Requirement form (HCA 12-411) completed by an LBAT.

II. It is the policy of Coordinated Care of Washington, Inc., that ***continuation*** *of ABA services* is medically necessary when meeting all the following:
   A. Member/enrollee's behavior concerns are not exacerbated by treatment,
   B. Member/enrollee has the cognitive ability to retain and generalize advancement in treatment goals,

C. Updated behavior assessment is completed every six months (or less, as clinically appropriate),
D. Documented coordination of care and communication regarding additional provider responsibilities (i.e., school, prescribers, and physical, occupational and/or speech therapists),
E. Updated treatment plan completed every six months (or less, as clinically appropriate) and includes all of the following:
    1. Documentation that ABA treatment will be delivered or supervised by an ABA-credentialed professional and is consistent with ABA techniques.
    Note: Supervision by a Lead Behavioral Analysis Therapist of care provided by a Certified Behavioral Therapist (CBT) should occur at a minimum of five percent of the total direct care per week (e.g., one hour of supervision per twenty hours of care).
    2. Qualitative and quantitative data meets all the following:
        a. Gathered from ABA providers as well as from parents/guardians, teachers, and other caregivers (such as speech therapists, occupational therapists),
        b. Collected in multiple settings, such as in a clinic, home, and school (as applicable),
        c. Includes a description of the change over time on all behaviors and skills that are the focus of treatment (includes graphs and data as applicable).
    3. Transition planning meets both of the following:
        a. Transition planning and discharge considerations made with input from the entire care team and involving a gradual step-down in services,
        b. Discharge criteria have been reviewed and adjusted according to progress and indicates the point at which services are appropriate for discontinuation and/or transfer to alternative or less intensive levels of care,
F. There is reasonable expectation that the member/enrollee will benefit from the continuation of ABA services due to one of the following:
    1. Documented progress toward goals since the last authorization (or an explanation of barriers to progress),
    2. Documentation supports that limited progress has been made toward goals since the last authorization, both of the following:
        a. Updated assessment identifies determining factors that may be contributing to inadequate progress,
        b. Changes to the treatment plan from the prior authorization period include all of the following:
            i) Reevaluation of each treatment plan goal,
            ii) Increased time and/or frequency working on targets,
            iii) Increased parent/caregiver training and supervision,
            iv) Identification and resolution of barriers to treatment effectiveness,
            v) Newly identified co-existing conditions, as applicable,
            vi) Consideration of alternative treatment settings,
            vii) Consideration of the effectiveness of ABA. Note: An updated, comprehensive diagnostic evaluation may be warranted to identify if psychological factors other than the autism spectrum disorder are impeding progress,

viii) Evaluation for other services that may be helpful for added support including but not limited to, speech therapy, occupational therapy, psychiatric evaluation, psychotherapy, case management, family therapy, feeding therapy, and school-based supports.

III. It is the policy of Coordinated Care of Washington, Inc., that *Early Childhood Intensive Behavioral Intervention Day Treatment Program (ECIBIDTP)* is medically necessary when:
   A. The member/enrollee has met criteria for Initial of ABA therapy and ECIBIDTP is ordered by the COE.

IV. It is the policy of Coordinated Care of Washington, Inc., that *ABA Services in the Inpatient Setting* are medically necessary when:
   A. The member/enrollee has met criteria for Initial of ABA therapy and all of the following:
      1. Inpatient setting is ordered by the COE who believes there is a reasonable expectation that the requested ABA services will result in measurable improvement in the member/enrollee's behavior or skills,
      2. 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,
      3. The member/enrollee's severe harmful behavior is preventing discharge to a less restrictive setting,
      4. The hospitalization or continued hospitalization has occurred because of the member/enrollee's severe harmful behavior.

V. It is the policy of Coordinated Care of Washington, Inc., that Applied Behavior Analysis (ABA) services may be appropriate for **discontinuation and/or transfer to alternative or less intensive levels of car**e when meeting any of the following:
   A. Member/enrollee has achieved the desired socially significant outcomes and treatment is not required to maintain functioning or prevent regression,
   A. Services are in lieu of school, respite care, or other community-based settings of care,
   B. There has been no clinically significant progress or measurable improvement towards treatment plan goals for a period of at least six months, and there is not a reasonable expectation that a revised treatment plan could lead to clinically significant progress,
   C. Treatment or intensity of treatment is being provided for the convenience or preference of the member/enrollee, parent/guardian, or other non-ABA service providers (school or other alternative providers),
   D. The decision is made by the family or the behavior analyst to end or temporarily suspend services due to (but not limited to) any of the following:
      1. The parent/caregiver can continue the behavior interventions independently,
      2. The parent/caregiver wants to discontinue services and withdraws consent for treatment,
      3. The parent/caregiver and provider are unable to reconcile essential issues in treatment planning and delivery,
      4. The parent/caregiver's circumstances or interest in treatment change,

5. The member/enrollee has transitioned to another provider or community resources for alternative treatment.

VI. It is the policy of Coordinated Care of Washington, Inc., that the following services are **not covered**:
   A. Autism camps
   B. Dolphin therapy
   C. Equine or Hippo therapy
   D. Primarily educational services
   E. Recreational therapy
   F. Respite care
   G. Safety monitoring services
   H. School-based health care services or early intervention program-based services under WAC 182-531A-0600
   I. Vocational rehabilitation
   J. Life coaching
   K. Treatment that is unproven or investigational, (e.g., holding therapy, Higashi, auditory integration therapy, etc.)

Background

Applied Behavioral Analysis (ABA) is the leading evidenced based, validated treatment for autism spectrum disorder (ASD). It is based on the premise that behavior is determined by past and current environmental events in conjunction with organic variables such as genetic attributes and physiological variables. It focuses on analyzing, designing, implementing, and evaluating social and other environmental modifications to produce meaningful changes in behavior. Services may be provided in various settings (e.g., home, clinic, school, community) and modalities (e.g., in-person, telehealth) to increase adaptive skills and decrease challenging behaviors. ABA includes the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. [1]

Council of Autism Service providers (CASP)[1]

The Council of Autism Service Providers (CASP) has developed guidelines and recommendations that reflect established research findings and best clinical practices. There are five core characteristic of applied behavior analysis (ABA) that should be present throughout all phases of assessment and treatment in the form of essential practice elements as follows:

Core characteristics of ABA treatment:

1. An objective assessment and analysis of the person's condition by observing how the environment affects their behavior, as evidenced through appropriate measurement.
2. Understanding the context of the behavior and the behavior's value to the person, their caregivers, their family, and the community.
3. Promotion of the person's dignity
4. Utilization of the principles and procedures of behavior analysis to improve the person's health, skills, independence, quality of life and autonomy.
5. Consistent, ongoing, objective data analysis to inform clinical decision making.

Essential practice elements:

1. A comprehensive assessment that describes specific levels of behavior(s) at baseline and informs the subsequent establishment of meaningful treatment goals.
2. An emphasis on understanding the current and future value or social importance of behavior(s) targeted for treatment.
3. Reasonable efforts toward collaboration with the person receiving treatment, their guardians if, applicable, and those who support them (e.g., caregivers, care team) in developing meaningful, treatment goals.
4. A practical focus on establishing small units of behavior that build toward larger, more significant changes in abilities related to improved health, safety, skill acquisition, and/or levels of independence and autonomy.
5. Collection, quantification, and analysis of direct observational data on behavioral targets during treatment and follow-up to maximize and maintain progress toward treatment goals.
6. Design and management of social and learning environment(s) to minimize challenging behavior(s) and maximize the rate of progress toward all goals.
7. An approach to the treatment of challenging behavior that links the function(s) of, or the reason(s) for, the behavior with programmed intervention strategies.
8. Use of a carefully constructed, individualized, and detailed behavior-analytic treatment plan that utilizes reinforcement and other behavioral principles and excludes methods or techniques not based on established behavioral principles and theory.
9. Use of treatment protocols that are implemented repeatedly, frequently, and consistently across environments until discharge criteria are met.
10. An emphasis on frequent, ongoing analysis and adjustments to the treatment plan based on patient progress.
11. Direct training of caregivers and other involved laypersons and professionals, as appropriate, to support increased abilities and generalization and maintenance of behavioral improvements.
12. A comprehensive infrastructure for case supervision by a behavior analyst of all assessments and treatment.

Services will fall into two treatment models Focused ABA and Comprehensive ABA[1]:

1. Focused ABA:
   Treatment provided directly to the member/enrollee for a limited number of behavioral targets. It is not restricted by age, cognitive level, or co-occurring conditions. Focused ABA treatment may involve increasing socially appropriate behavior (e.g., increasing social initiations) or reducing problem behavior (e.g., aggression) as the primary target. Focused ABA plans are appropriate for individuals 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.

2. Comprehensive ABA:
   Treatment of the multiple affected developmental domains, such as cognitive, communicative, social, emotional, and adaptive functioning. Maladaptive behaviors, such as noncompliance, tantrums, and stereotypy are also typically the focus of treatment. Intensity levels range from 30-40 hours of treatment per week (plus direct and indirect supervision and

caregiver training); however, the intensity of comprehensive treatment must be individualized to the person's characteristics and other factors.

Council of Autism Service Providers (CASP) Practice Parameters for Telehealth-Implementation of Applied Behavior Analysis[2]
Due to a shortage of providers and disparities which exist in behavioral health care access, telehealth services have become a viable solution to address health access to treat members/enrollees with ASD. This service is not intended to replace in person service, as it is intended to supplement the traditional in person service delivery model.[4]" Clinical decisions on telehealth service delivery models should be selected based on the individual needs, strengths, preference of service modality, caregiver availability and environmental support available. Providers should refer to respective state allowances for telehealth services and reference the most updated CASP Practice Parameters for Telehealth-Implementation of Applied Behavior Analysis.

American Academy of Pediatrics (AAP)[3]
The AAP recommends that all children be screened for ASD at ages 18 and 24 months, along with regular developmental surveillance. Toddlers and children should be referred for diagnostic evaluation when increased risk for developmental disorders (including ASD) is identified through screening and/or surveillance. Although symptoms of ASD are neurologically based, they manifest as behavioral characteristics that present differently depending on age, language level, and cognitive abilities. Core symptoms cluster in 2 domains (social communication, interaction, and restricted, repetitive patterns of behavior), as described in the DSM-5TR.

The Diagnostic and Statistical Manual of Mental Disorder, Fifth edition (DSM-5-TR)[4]
The Diagnostic and Statistical Manual of Mental Disorder, list the following as the severity levels for autism spectrum disorders. They are divided into two domains (social communication and social interaction and restrictive, repetitive patterns of behaviors) To fulfill diagnostic criteria for ASD by using the DSM-5 TR, all 3 symptoms of social affective difference need to be present in addition to 2 of 4 symptoms related to restrictive and repetitive behaviors.

Severity Level	Social Communication	Restricted, repetitive behaviors
Level 3 "Requiring very substantial support"	Severe deficits in verbal and nonverbal social communication skills cause 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/she does, makes unusual approaches to meet needs only and responds to only very direct social approaches.	Inflexibility of behavior, extreme difficulty coping with change or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changes focus or action.
Level 2 "Requiring substantial support"	Marked deficits in verbal and nonverbal communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interest, and who has markedly odd nonverbal communication.	Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer in a variety of context. Distress and/or difficulty changing focus or action.

Level 1 "Requiring support"	Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions. For example, a person who can speak in full sentences and engages in communication but who is to and from conversation with others fails, and who attempts to make friends are odd and typically unsuccessful.	Inflexibility of behavior cases significant interference with functioning in one or more context. Difficulty switching between activities. Problems of organization and planning hamper independence.

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 2023, 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 and applicable state 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 one patient, each 15 minutes
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes
97154*	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes

CPT®* Codes	Description
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
99366	Team conference w patient
99368	Team conference w/o patient
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

*Claims must be billed with an appropriate modifier to identify the number of families or clients attending:

UN	Parent training – 2 families. Skill training/development – 2 clients
UP	Parent training – 3 families. Skill training/development – 3 clients
UQ	Parent training – 4 families. Skill training/development – 4 clients
UR	Parent training – 5 families. Skill training/development – 5 clients
US	Parent training – 6+ families. Skill training/development – 6+ clients

HCPCS Codes	Description
H2020	Therapeutic behavioral services, per diem

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy adopted. Previously WA.UM.35	08/19	11/19
Annual Review. Renumbered policy, was WA.CP.MP.104. Moved to standard corporate policy, with state-specific requirements for Center of Excellence, DSM Checklist and use of HCPCS H2020.	08/20	09/20

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Annual review. Reference list reviewed and updated. Changed "Review Date" in the header to "Date of Last Revision". Changed "members" to "members/enrollees." Corrected typo.	08/21	09/21
Addition of treatment range for focused ABA and literature review in introduction. Addition of medical necessity criteria for behavioral assessment. Addition of intensity of services for ABA. Addition of "or appropriate diagnosis as otherwise specified according to state defined ABA criteria" and removal of "clinical professional counselor, marriage and family therapist, addiction counselor", addition of "strengths-specific, family-focused, community-based, multi-system, culturally-competent, and least intrusive. And where specific target behaviors are clearly defined; frequency, rate, symptom intensity or duration" in criteria. Section III.D. updated definition. Addition of H, K, L, M in initiation of services criteria. Addition of K, L, M, N in continuation of ABA services criteria. Addition of transition planning section. Updated introduction and research studies including citations to section entitled "Background." Addition of section Screening Recommendations for ASD. Edit of verbiage for caregiver training goals changed "Caregiver Training is performance based. Identifies measurable outcomes for every goal and objective including parent training" to "Caregiver training is performance based and parent driven. Identifies measurable outcomes for every goal and objective".	09/22	09/22
Policy retired. Will use CP.BH.104.	2/23	2/23
Policy re-activated using 12/24 version of CP.BH.104.	08/25	

References

1. The Council of Autism Service Providers (CASP) Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers, Third Edition. https://www.casproviders.org/standards-and-guidelines. Updated April 29, 2024. Accessed November 04, 2024.
2. The Council of Autism Service Providers. Practice Parameters for Telehealth-Implementation of Applied Behavior Analysis: Second Edition.https://www.casproviders.org/practice-parameters-for-telehealth/. Updated December 1, 2021. Accessed November 04,2024.
3. American Academy of Pediatrics: AAP Recommendations. https://www.aap.org/en/patient-care/autism/. Website Accessed November 04, 2024.
4. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision. https://doi.org/10.1176/appi.books.9780890425787. Published March 8,2022. Accessed November 04, 2024.
5. Augustyn M, Hahn LE, Autism spectrum disorder in children and adolescents: Evaluation and diagnosis. UpToDate. https://www.uptodate.com. Published May 16, 2022. Accessed November 04, 2024.

6. Weismann, L. Autism spectrum disorder in children and adolescents: Screening tools. UpToDate. https://www.uptodate.com. Updated January 24,2024. Accessed November 04,2024.
7. Weismann, L. Autism spectrum disorder in children and adolescents: Behavioral and educational interventions. UpToDate. https://www.uptodate.com. Updated October 22, 2024.Accessed November 04,2024.
8. Health Technology Assessment. Comparative Effectiveness Review of Intensive Behavioral Intervention for Treatment of Autism Spectrum Disorder. Hayes. www.hayesinc.com. Published March 13, 2019 (annual review February 10, 2022). Accessed November 04,2024.
9. Health Technology Assessment. EarliPoint (EarliTec Diagnostics Inc.) as an Aid in Diagnosis of Autism Spectrum Disorder in Children. Hayes. www.hayesinc.com. Published April3, 2024. Accessed November 04,2024.
10. Washington State Administrative Code (WAC) 182-531A. Chapter 182-531A WAC: Accessed August 28, 2025.
11. Washington State Health Care Authority. *Applied Behavioral Analysis (ABA) Program Billing Guide*. Applied Behavior Analysis (ABA) Program Billing Guide Revised July 1, 2025.

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.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.