MEDICAL POLICY STATEMENT
GEORGIA MEDICAID

Original Issue Date	Next Annual Review	Effective Date
11/29/2017	03/01/2019	03/01/2018
Policy Name		**Policy Number**
Applied Behavior Analysis/Services (ABA/ABS)		MM-0212
Policy Type		
MEDICAL	Administrative / Pharmacy	Reimbursement

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

Contents of Policy

A. SUBJECT

Applied Behavior Analysis/Services (ABA/ABS) for the treatment of Pervasive Developmental Disorders including Autism Spectrum Disorder.

B. BACKGROUND

Autism Spectrum Disorder (ASD) can vary widely in severity and symptoms, depending on the developmental level and chronological age of the patient. Autism is often defined by specific impairments that affect socialization, communication, and stereotyped (repetitive) behavior, which collectively are called the "Core" symptoms of autism. Children with autism spectrum disorders have pervasive clinically-significant deficits which are present in early childhood in areas such as intellectual functioning, language, social communication and interactions, as well as restricted, repetitive patterns of behavior, interests and activities. Individuals with a well-established diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder NOS under previous diagnostic criteria should be given the diagnosis of ASD.

There is currently no cure for ASDs, nor is there any one single treatment for the disorder. Some individuals with ASDs may be managed through a combination of therapies, including behavioral, cognitive, pharmacological, and educational interventions. The goal of treatment for autistic patients is to minimize the severity of autism symptoms, maximize learning, facilitate social integration, and improve quality of life for both autistic individuals and their families or caregivers.

Behavioral therapy programs studied to treat ASD include Intensive Behavioral Intervention (IBI), including Lovaas therapy, Early Intensive Behavioral Intervention (EIBI), or Applied Behavior Analysis/Services (ABA/ABS). IBI therapy involves use of operant conditioning, a behavioral modification technique using positive reinforcement to increase desired behaviors, or a neutral response to not reinforce undesired behaviors. The operant conditioning is delivered in a highly-structured and intensive program, with one-to-one instruction by a trained therapist. Caregivers are active participants in the therapy when a child is young, usually by 3 years of age.

These intensive behavioral intervention programs involve time-intensive, highly-structured positive reinforcement techniques by a trained behavior analyst or therapist. There is a wide variation in ABA/ABS practices from philosophy, approach, interventions and methodology, and outcome reporting. Clinical evidence from small studies and meta-analyses suggests that intensive behavioral therapy may have effects on intellectual functioning, language-related outcomes, acquisition of daily living skills and social functioning for some individuals. Methodological problems including small sample sizes (limiting statistical analysis), lack of randomization, blind assessments, and use of prospective design limit the generalizability of the results. There is lack of definition and guidelines around characteristics of children who would benefit from treatment, lack of evidence-based guidelines for training and credentialing, program content, measurement of success, intensity, duration and clinical criteria. CareSource fully supports the recommendation for ongoing research, randomized control studies, standardized protocols, and longitudinal research to determine long term outcomes.

The following professional societies' recommendations are derived from the latest guidelines and scientific based literature available.

American Academy of Pediatrics (AAP)

The AAP states children that receive early intensive behavioral treatment have been shown to make substantial, sustained gains in IQ, language, academic performance, adaptive behavior and social behavior.

American Academy of Child and Adolescent Psychiatry (AACAP)

The AACAP has practice parameters for treatment of children and adolescents with ASD. The quality of the literature is variable. None of the treatment models has emerged as superior.

C. DEFINITIONS

- Refer to state-specific provider definitions

D. POLICY

I. CareSource supports early intervention services and therapies, such as physical, speech, occupational therapy, as well as psychological/psychiatric services, for the treatment of autism spectrum disorders.

II. CareSource provides for state and federal required covered services as part of a comprehensive plan of treatment for autism spectrum disorders when ordered by a licensed physician who specializes in treating children, child neurologist or child psychiatrist and provided/supervised by a certified, credentialed and/or licensed CareSource participating BCBA at the Doctorate or Master's degree level.

III. **Diagnosis**

A. Diagnosis should be made and confirmed in early childhood by one of the following: Autism Diagnostic Observation Schedule (ADOS), Autism Diagnostic Interview (ADI), or the Diagnostic Interview for Social, Communication Disorders (DISCO). Other known evidence-based diagnostic tools may be used, but only in support of the tools listed here. The final diagnosis must be made by a licensed psychologist or physician. The following must be ruled out as causal reasons for behavior:

1. Primary hearing deficits;
2. Primary speech disorder;
3. Heavy metal poisoning (as diagnosed by a physician).

B. Severity Levels for Autism Spectrum Disorders, as outlined by the American Psychiatric Association are as follows:

Severity Level	Social Communication	Restricted, Repetitive Behaviors
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 is able to speak in full sentences and engages in communication but whose to and fro conversation with others fails, and who attempts to make friends are odd an 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.
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	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

	to narrow special interest, and who has markedly odd nonverbal communication.	context. Distress and/or difficulty changing focus or action.
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.

IV. **Treatment**

A. Prior authorization is required for ABA services provided to CareSource members. Please see Attachment A for a Prior Authorization Checklist.

B. The prior authorization request for treatment must be accompanied by the following:

1. Assessment for Autism/ASD confirmed diagnosis;
2. Medical necessity-Licensed medical professional (MD), BCBA, or other qualified health care professional as is consistent with state licensing requirements
   - 2.1 If applicable, documentation of less intensive behavior treatment or other therapy 60-90 days in duration that has not been sufficient to reduce interfering behaviors, to increase pro-social behaviors, or to maintain desired behaviors;
   - 2.2 Clinical rationale for prescribing ABA/ABS.
3. Assessment with all of the following information:
   - 3.1 Child's history and psycho-social history;
   - 3.2 Previous therapies;
   - 3.3 Current therapies and other interventions (i.e. medication) ;
   - 3.4 Previous ABA/ABS and results;
   - 3.5 Copy of Individualized Education Plan (IEP) or Individual Family Service Plan (IFSP);
   - 3.6 Behaviors to be targeted that show clinically significant health or safety risk to self or others and when the behaviors typically occur;
   - 3.7 Caregivers and others in the child's community (all providers, supports and resources) who will be involved in the training;
   - 3.8 Scores or objective measurements/testing score from an instrument used to confirm a diagnosis of ASD such as ADOS, ADI or DISCO;
   - 3.9 Attestation letter from the provider regarding ABA services the child is receiving in ADDITION to requested services (i.e. school based ABA/ABS under an IEP or in the context of Early Intervention-IFSP OR a copy of the IEP or IFSP).

C. Treatment for Autism Spectrum Disorder (ASD) must:

1. Demonstrate that Applied Behavioral Analysis/Services (ABA/ABS) is not custodial, or maintenance oriented in nature;
2. Include coordination across all providers, supports and resources;
3. Identify parent, guardian and/or caregiver involvement in prioritizing target behaviors, and training in behavioral techniques in order to provide additional supportive interventions;
4. Include criteria and specific behavioral goals and interventions for lesser intensity of care and discharge;

5. There is evidence of identified and involved community resources;
6. There must be a reasonable expectation that the member can benefit from the services proposed.

D. For children with an Autism Spectrum Disorder diagnosis, therapy can range from 10-30 hours per week, or more if medically necessary, and requires active parent/caregiver participation and involvement in order to increase the potential for behavior improvement and/or changes in those behaviors identified as causing limitations or deficits in FUNCTIONAL skills that a child would normally have.

E. The member must exhibit behaviors that present as clinically significant health or safety risk to self or others, or are behaviors that are significantly interfering with basic self-care, communication or social skills.

F. Members/Caregivers must be able to participate in ABA/ABS therapy and have the ability to implement ABA/ABS techniques in the home environment as instructed by their behavior analyst. If they are unwilling/unable to implement therapeutic interventions in the home consideration will be given to other modalities of treatment as ABA/ABS needs to be consistently applied in all environments in order for it to be successful. Use of ABA/ABS in no way precludes other treatment inventions with ABA/ABS such as physical therapy (PT), occupational therapy (OT), and other forms of behavioral therapy, family therapy, and/or medication management.

V. Plan of Care/Care Plan

A. Care plans should include:
1. Interventions to be utilized;
2. Objective and measurable goals tailored to each individual patient and which behaviors they target;
3. Time frames for all goals;
4. Expected schedule for requested services and subsequent treatment;
5. How the caregiver/family will be incorporated in the care plan;
6. Where the ABA/ABS will be delivered such as home, office, and/or school;
7. Estimated date of mastery;
8. Plan for generalization of skills;
9. Transition;
10. Discharge planning;
11. The number of service hours needed to meet goals.

B. Care Plans should be updated at a minimum of every 6 months or more frequently when a lesser time period was requested/approved and should include:
1. Number of sessions completed;
2. Updated information as to individual goals met, partially met and progress toward all goals;
3. New or updated goals;
4. New time frame for goals;
5. Summary of carryover of skills/education to family/caregivers and others in the child's community;
6. Progress with family/caregiver adherence to plans/techniques for use in the home and community;
7. Coordinate services both in and out of school setting;
8. Rationale for continuation of services;
9. Documentation of clinically significant progress as measured by a standardized assessment of adaptive function, communication skills, and/or social skills.

VI. **Documentation**

A. Clinical documentation should be submitted with ALL of the following information for each goal on the Care Plan:
   1. Date and time of session (start and end time);
   2. Place of Service;
   3. Billing code;
   4. All participants;
   5. Progress to date relative to baseline measurement;
   6. Techniques used;
   7. Caregiver or others involvement in the session;
   8. Plan for next session;
   9. Group sessions should be documented as such and should include the place and number of participants;
   10. Evidence of the occurrences of challenging behaviors that show improvement over time (i.e., graphs or charts); and,
   11. Notes shall be signed by the rendering provider (person providing the session).

B. Clinically significant progress in social skills, communication skills, language skills, and adaptive functioning or other areas of concern must be documented as follows:
   1. Interim progress assessment at least every 6 months based on clinical progress toward treatment goals;
   2. Developmental status as measured by standardized assessments no less frequent than every 2 years;
   3. Family education and training interventions including the behavior parents/caregivers are expected to demonstrate and utilize outside the treatment setting (i.e. home or community);
   4. How many sessions were provided

C. If an individual is unable to demonstrate progress toward meeting the majority of goals after two six month periods of ABA/ABS treatment, then consideration will be given as to whether or not there is a reasonable expectation that the child is capable of making progress with ABA/ABS. If so, then the individual no longer meets criteria for continued ABA/ABS therapy and other modalities may be offered.
   1. There must be a reasonable expectation that the child will continue to benefit from the continuation of ABA services and that continuation is NOT for the benefit of the family, caregivers or treating therapist.
   2. The treatment should NOT be making symptoms worse, or showing as regression in any additional therapies targeting skill acquisition (understanding the importance of coordinating ABA services with any other modality/service/therapy being received by the child at the same time).

VII. **Non-Indicated Services; Services Not Covered**

A. ABA/ABS treatment is **not covered** for symptoms and/or behaviors that are not part of core symptoms of autism (e.g., impulsivity due to ADHD, reading difficulties due to learning disabilities, or excessive worry due to an anxiety disorder). Additional services will be considered to treat symptoms not associated with autism.

B. If academic or adaptive deficits are included in the ITP, then the focus should be on addressing autistic symptoms that are impeding these deficits in the home environment (i.e. reduce frequency of self-stimulatory behavior to allow child to be able to follow through with toilet training or complete a mathematic sorting task) rather than on any academic targets.

C. ABA/ABS treatment is not covered for more than one program manager/lead behavioral therapist for a member at any one time;

D. ABA/ABS treatment is not covered for more than one agency/organization providing ABA services for a member at any one time;
E. ABA/ABS treatment is not indicated nor will it be covered for activities and therapy modalities that do not constitute application of ABA/ABS analysis techniques for treatment of autism. Examples include, but are not limited to:
   1. Taking member to appointments or activities outside of the home (i.e. recreational activities, eating out, shopping, medical appointments, etc.)
   2. Assisting the member to with academic work or functioning as a tutor, educational or other aide for the member in school;
   3. Provision of services that are part of an IEP and therefore should be provided by school personnel, or other services that schools are obligated to provide;
   4. Doing house work or chores, or assisting the member with house work or chores except when the member has demonstrated a pattern of significant behavioral difficulties during specific house work/chores, or acquiring the skills to do specific house or chores is part of the ABA/ABS treatment plan for member.
   5. Travel time.
   6. Speech Therapy.
   7. Occupational Therapy.
   8. Vocational Rehabilitation.
   9. Supportive Respite Care.
   10. Recreational Therapy.
   11. Orientation and mobility skills.
   12. ABA/ABS provided in the school.

E. CONDITIONS OF COVERAGE

HCPCS
CPT
AUTHORIZATION PERIOD

F. RELATED POLICIES/RULES

Attachment A, Applied Behavior Analysis/Services (ABA/ABS) Prior Authorization Checklist

G. REVIEW/REVISION HISTORY

DATES		ACTION
Date Issued	11/29/2017	New Policy.
Date Revised		
Date Effective	03/01/2018	

H. REFERENCES

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The Medical Policy Statement detailed above has received due consideration as defined in the Medical Policy Statement Policy and is approved.

ATTACHMENT A:

APPLIED BEHAVIOR ANALYSIS/SERVICES (ABA/ABS)

Prior Authorization Checklist

1. Prior Authorization Form

Is all of the patient information complete?

Is all of the provider information completed?

Have you included an appropriate diagnosis per policy?

Have you included all of the appropriate diagnosis per policy?

Have you included all the appropriate procedure codes, modifiers and units?

Has a Qualified Health Practitioner ordered the services?

2. Diagnostic Assessment

Has an ADOS, ADI, or DISCO been completed and is the documentation attached?

Has the diagnostic test been signed by one of the following?

- Licensed physician.
- Licensed psychologist.

Is there documentation of member's current symptoms meeting the criteria for ASD in the past year? Does the assessment include a referral for ABA services?

3. Care Plan

Does the treatment plan identify ALL of the below?

- Behaviors to be targeted
- Psychological concerns
- Medical concerns
- Family issues affecting member or affected by member condition
- Hours spent in school (includes home school)
- Current therapies

Is the assessment/evaluation documentation supporting the care plan attached?

ATTACHMENT A (CON'T):

Measurable goals: (applies to all care plan goals)

- Has a baseline measurement been performed and documented for this goal?
- Has a timeline been established for ameliorating this behavioral in a measurable way?
- Has the provider performing therapy been identified? (RBT, BCaBA, BCBA)
- Have the hours requested for each goal been substantiated?

Parental Training:

- Has the modality (video review, role-playing, lecture, etc.) been clearly identified?
- Has the frequency (times per week/month) been identified and substantiated?
- Has the duration of hours (per session) been identified and demonstrated?
- Has the provider performing parental training been identified? (RBT, BCaBA, BCBA)

Has a school transition plan been developed (either short or long term) and included in the overall treatment plan?