Clinical Policy: Applied Behavioral Analysis (ABA)

Reference Number: KS.CP.01
Last Review Date: 06/2019

Coding Implications
Revision Log

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

Description

This policy applies to Utilization Management and Appeals department when processing Applied Behavioral Analysis (ABA) requests.

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.

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).

When requests are received for ABA services for Medicaid, Medicare, or Ambetter, UM and appeals clinical reviewer is to utilize the below criteria to review and determine medical necessity. The codes below are to be used for reviewing ABA service requests for Kansas Medicaid, Medicare, and Ambetter members. The procedure provides the prescribed method to follow. It includes who, what, when, where, and how steps are to be completed.

Policy/Criteria

I. It is the policy of Sunflower Health Plan® that Applied Behavioral Analysis (ABA) is medically necessary for the following indications:

- **A.** Fully completed Autism Authorization Request Form (including dated provider signature)
- **B.** Documentation of original Autism diagnosis
  - **1.** Psychological evaluation – MD or licensed psychologist has evaluated w/in last 6 months for current validation of Autism diagnosis.
- **C.** Doctor recommendation of services/prescription/order to treat.
- **D.** Criterion referenced standardized assessment
  - **1.** Vineland-III, ADOS, CARS, ADI-R, GARS, ASDS
- **E.** Skills Based Assessment

1. VB-MAPP, ABLLS, AFLS, ASRS,

F. Current Kan Be Healthy Assessment
1. Completed by a physician, APRN, PA or credentialed RN
2. Must be completed within the past year
3. This requirement does not apply for Ambetter members

G. The treatment plan is built upon individualized goals and projected time to achieve those goals with measurable objectives tailored to the member. Treatment is either focused or comprehensive based on the following guidelines:
1. Focused ABA treatment meets both of the following:
   a. Identifies hourly breakout for individual and group hours ranging from 10 – 25 hours per week including 1:1 direct and indirect, group, supervision and caregiving training.
   b. Identifies measurable outcomes for every goal and objective.
   c. Soft limit or no more than 50 hours per year of BCBA/Autism Specialist and no more than 25 hours per week of 1:1 support. Additional documentation will be required to exceed those soft limits.
2. Comprehensive ABA treatment plan meets all of the following:
   a. Identifies hourly breakout for individual and group hours ranging from 25 - 40 hours per week inclusive of all 1:1 direct and indirect, group, supervision, and caregiver training.
   b. Identifies measureable outcomes for every goal and objective.
   c. Hours of therapy per day are individualized with the goal of increasing or decreasing the intensity of therapy as the member's ability to tolerate and participate permits.

H. The plan of care includes an initial discharge plan outlining desired outcomes for treatment goals.

I. Roles and responsibilities of all providers, as well as effective dates for behavioral targets that must be achieved prior to the next phase of care, should be specified and coordinated with all providers, the member and family members.

J. Parent or caregiver training and support is incorporated into the treatment plan.

K. Interventions are consistent with ABA techniques.

II. The *continuation of ABA services for the 6 month update request* is considered **medically necessary** when all of the following criteria are met:

A. Fully completed Autism Authorization request form (including dated provider signature).

B. Skills Based Assessment: VB-MAPP, ABLLS, AFLS, ASRS

C. There is reasonable expectation that the member will benefit from the continuation of ABA therapy, as evidenced by mastery of skills defined in initial plan, or a change of treatment approach from the initial plan.

D. The interventions are consistent with ABA techniques.

E. The treatment plan documents progress toward goals and is submitted for review every 3-6 months, or as state-mandated.

F. The number of service hours necessary to effectively address the challenging behaviors is listed in the treatment plan and considers the member's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service, group and supervision hours.

G. Roles and responsibilities of all providers, as well as effective dates for behavioral targets that must be achieved prior to the next phase, should be specified and coordinated with all providers, member and family members.

H. Treatment hours are subsequently increased or decreased based on response to treatment and current needs.

I. Treatment is not making the symptoms worse.
J. There is a reasonable expectation, based on the member's clinical history that withdrawal of treatment will result in decompensation/loss of progress made, or recurrence of signs and symptoms.

III. The *continuation of ABA services for the annual update request* is considered **medically necessary** when all of the following criteria are met:
A. Fully completed Autism Authorization request form (including dated provider signature).
B. Criterion referenced standardized assessment
  1. Vineland – III, ADOS, CARS, ADI-R, GARS, ASDS
  2. Skills Based Assessment – VB-MAPP, ABLLS, AFLS, ASRS
C. Current Kan Be Healthy Screening – done yearly, (Well Child Exam is not the same assessment).
  1. Completed by a physician, APRN, PA or credentialed RN
  2. Must be completed within the past year
  3. This requirement does not apply for Ambetter members
D. The treatment plan is built upon individualized goals and projected time to achieve those goals with measurable objectives tailored to the member. Treatment is either focused or comprehensive based on the following guidelines:
  1. Focused ABA treatment meets both of the following:
    a. Identifies hours breakout for individual and group hours ranging from 10 – 25 hours per week including 1:1 direct and indirect, group, supervision and caregiving training.
    b. Identifies measurable outcomes for every goal and objective.
    c. Soft limit or no more than 50 hours per year of BCBA/Autism Specialist and no more than 25 hours per week of 1:1 support. Additional documentation will be required to exceed those soft limits.
  2. Comprehensive ABA treatment plan meets all of the following:
    a. Identifies hourly breakout for individual and group hours ranging from 25 - 40 hours per week inclusive of all 1:1 direct and indirect, group, supervision, and caregiver training.
    b. Identifies measureable outcomes for every goal and objective.
    c. Hours of therapy per day are individualized with the goal of increasing or decreasing the intensity of therapy as the member's ability to tolerate and participate permits.
E. The plan of care includes an initial discharge plan outlining desired outcomes for treatment goals.
F. Roles and responsibilities of all providers, as well as effective dates for behavioral targets that must be achieved prior to the next phase of care, should be specified and coordinated with all providers, the member, and family members.
G. Parent or caregiver training and support is incorporated into the treatment plan.
H. Interventions are consistent with ABA techniques.

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
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

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
Original approval date	5/1/19	6/4/19

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23. Policy: CP.MP.104

Definitions

KAN Be Healthy screen (KBH) – Early and Periodic Screening, Diagnostic, and Treatment Screening (EPSDT)
Vineland-3 = Vineland Adaptive Behavior Scales, 3rd Edition
ADOS-2 = Autism Diagnostic Observation Schedule, 2nd edition
CARS2 = Childhood Autism Rating Scale 2nd edition
ABLLS-R = Assessment of Basic Language & Learning Skills, Revised
VB-MAPP = Verbal Behavior Milestone Placement Program
AFLS = Assessment of Functional Living Skills

ASRS = Autism Spectrum Rating Scales (parent report)
ATEC = Autism Treatment Evaluation Checklist (parent questionnaire)
BASC-3 = Behavior Assessment System for Children
Bayley-III = Bayley Scales of Infant and Toddler Development, 3rd edition
Mullen Scales= The Mullen Scales of Early Learning

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.

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.

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.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.