Applied Behavioral Analysis for Autism Spectrum Disorders

I. Diagnosis Codes for ASD

A. For the purposes of this Policy, Minuteman Health (MHI) will require the use of the following ICD 10 Diagnosis codes for ABA services to be considered.

ICD 10Code	Description
F84.0 – F84.9	Autistic disorder

Coverage is provided consistent with Chapter 207 of the Acts of 2010 - An Act Relative to Insurance Coverage for Autism in the Commonwealth of Massachusetts.

ABA includes the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior. It also includes the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Under New Hampshire law, RSA 417-E:2(I)(a) to be eligible for coverage, applied behavior analysis must be provided by a person professionally certified by the national Behavior Analyst Certification Board or performed under the supervision of a person professionally certified by the national Behavior Analyst Certification Board. In Massachusetts, to be eligible for coverage, ABA may be provided by (but is not limited to): a physician; a psychologist; or an In-Plan provider who is an autism services provider (such as a board certified behavior analyst).

A Board Certified Behavior Analyst (BCBA) professional conducts behavioral assessments, designs and supervises behavior and analytical interventions and also develops and implements assessments and interventions for members with diagnoses of autism spectrum disorders.

A BCBA may supervise the work of other BCBAs and other ABA Paraprofessionals who implement behavior and analytic interventions.

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Habilitative care is provided by professionals and is "necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of an individual" diagnosed with an Autism Spectrum Disorder.

B. To bill for ABA services, the Provider must be contracted and credentialed by MHI and meet one of the following criteria:
   1. Be actively certified as a BCBA by the Behavior Analyst Certification Board (BACB); or
   2. Have a minimum of 6 months of supervised experience delivering ABA; or
   3. Have completed at least 3 graduate-level classes (9 credits) focused entirely upon behavior modification, psychology of learning, or Early Intensive Behavioral Interventions, at least one course of which is specifically devoted to ABA; or
   4. Have completed at least 40 hours of continuing education credits on behavior modification, psychology of learning, or Early Intensive Behavioral Interventions, at least one course of which is specifically devoted to ABA.

C. To bill for ABA services delivered by a paraprofessional, the Provider must meet all of the criteria to bill for ABA services and perform ALL of the following for each paraprofessional that he or she supervises:
   1. Provide clinical oversight to each paraprofessional
   2. Assume ultimate responsibility for ABA services delivered by the paraprofessional
   3. Agree not to bill for ABA services delivered by a member of the patient's family
   4. Perform a Criminal Offender Record Information (CORI) check on each paraprofessional
   5. Verify that each paraprofessional holds a Bachelor's degree from an accredited institution of higher education
   6. Inform the member who receives services from a paraprofessional and the member's caregiver of the paraprofessional status

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7. Create and maintain a medical record and ensure that each hour of service is appropriately documented.

II. Criteria for approval

A. MHI may authorize ABA therapy visits and/or habilitative care visits after a comprehensive diagnostic evaluation by a Neurologist, Pediatric Neurologist, Developmental Pediatrician, Member of Certified Early Intervention Team, Psychologist , Psychiatrist or a Pediatrician certified to use an accepted diagnostic tool, such as the Autism Diagnostic Observation Scale (ADOS), experienced in the diagnosis of ASD and with a referral (as needed) when **all** of the below are met:

1. The Member has a definitive diagnosis of an Autism Spectrum Disorder from a Neurologist, Pediatric Neurologist, Developmental Pediatrician, Member of Certified Early Intervention Team, Psychologist or Psychiatrist experienced in the diagnosis and treatment of ASD **and;**

2. From initial evaluation through the entire course of treatment, **all** of the following must be met:
   a. Documentation must support the position that therapy will achieve functional gains beyond those expected as a result of growth and maturation and there is clear evidence that the symptoms of the illness are active, resulting in substantial impairment in daily functioning **and;**

   b. There is a clear treatment plan, measurable goals and approaches that address the signs and symptoms of the illness **and;**

   c. There is no less intensive or more appropriate level of services which can be safely and effectively provided **and**

   d. ABA services including habilitative services must be provided or supervised by a BCBA or by a licensed provider **and;**

   e. The Member's parent(s)/legal guardian (when the member is under 18 years old) is involved in the member's treatment setting **and;**

   f. The Member's condition can be classified and billed with the codes listed above.

3. Under New Hampshire Law, 420-B:8-b(i)(B) , MHI shall allow its subscribers 2 visits for diagnosis followed by up to 3 treatment visits in each contract year. In Massachusetts, this

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does not apply. Prior authorization is allowable under Massachusetts law for all ABA services. For ongoing services concurrent review is required. When requesting services the Provider should submit the Member's most recent individualized educational plan (IEP) as developed by the local school department or the Individualized Service Plan (ISP) when applicable and the appropriate ABA and Autism Habilitative Services request form. In submitting the IEP, the Provider must seek the parents' authorization to release that information from the school and not contact the school directly for that release.

4. The amount of hours or units of services authorized shall correspond to the severity and complexity of the member's condition.

III. Required Documentation

A. All authorization for treatment is based on documentation of medical necessity for specific treatment goals to address specific behavioral targets. In accordance with New Hampshire law, RSA 417 E:2(IV), an insurer may require an updated treatment plan no more frequently than on a semi-annual basis. This limit is not required in Massachusetts. The following is a guide to what is expected in individual treatment plans for members with ASD.

B. Treatment plans should include:

1. Goals that relate to the core deficits of ASD and should be derived from the functional assessment and/or skills-based assessments that occur prior to initiating treatment.

2. Linkage and coordination with other behavioral health and medical providers who are concurrently providing services with the member/parent/guardian's documented consent and available peer, community, and school based (Individualized Family Service Plan/Individualized Education Plan) providers.

3. Measurable Objectives to address each skill deficit and behavioral excess goal.

4. Target dates for introduction of and mastery of the objectives.

5. Data from baseline levels for each identified goal.

6. A Transition Plan. If appropriate, the goals of a transition plan may include the level of supports a child needs in order to be successful when moving from one level of care to another, the skills the child is currently being taught to facilitate the transition, and the level of communication between the BCBA or Licensed Mental Health Clinician and any other related allied professionals such as the child's teacher, speech therapist, occupational

therapist, social worker, and or counselor. Transition plans may include several components depending on the child's situation. A transition plan should be created when:

a. The child begins treatment.

b. The child is preparing to transition from a home-based *intensive* ABA-based program to a lesser level of care.

c. The child is preparing to transition from a most to least restrictive environment placement.

d. The child is preparing to transition from a home-based ABA intervention program to a school-based program.

e. A transition plan should also address how the child will transition into adulthood.

7. Discharge Criteria must include requirements for discharge, discharge date, next level of care, and linkages with other services.

8. Behavioral Intervention Plan should be included if clinically necessary. Behavior plans should include a definition of the behavior, antecedents, consequences, prevention, baseline, and any de-escalation procedures.

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9. Individualized steps for the prevention and/or resolution of crisis, (i.e. identification of crisis antecedents and consequences):

    a. Active steps or self-help methods to prevent, de-escalate, or defuse crisis situations.

    b. Names and phone numbers of contacts that can assist member in resolving crisis, such as other treatment providers that may assist in the prevention or de-escalation of behaviors, even for those members who do not currently display aberrant behaviors.

10. Supervision must be delivered to paraprofessional or BCABA level staff at the following level:

    a. A minimum of 90 minutes supervision per month is expected for each BCABA or paraprofessional. The maximum hours approved are based on the member's direct hours, i.e., one (1) hour supervision for every 10 hours of direct service. Supervision may be a combination of group, individual, or in vivo modalities.

11. Parent/Guardian management skills that can be generalized to the home. It is required that parent goals and/or parent training is a part of each treatment plan.

    a. Document any assistance provided to caregivers or others to carry out the approved behavior support/maintenance plans.
    b. Provider observation of the caregivers or other plan implementers and the member's behaviors to assess proper implementation of the behavior support/maintenance plan and interventions made based on those observations.

12. Incremental functional gains should be achieved not only during training sessions but between training sessions as well, demonstrating that the service is affecting clinical gains independent of direct contact with ABA clinicians, that the parents/primary care-takers are learning how to implement the treatment interventions.

13. Further it is expected that providers are continually monitoring a member's progress in all areas of functioning. The treatment is expected to be modified as the parents/guardians management skills improve, and the member's deficits are modified.

14. In the Concurrent Review include any updates to the crisis resolution plan outlined in the Initial Treatment Plan. Note any on-site assistance provided in difficult or possibly crisis

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situations.

15. Treatment Plan updates will be reviewed at a frequency as required by state-specific or account-specific requirements.[1] The Treatment Plan update should reflect any major life changes and the member's progress in the goals, objectives, and targets identified on the Initial Treatment Plan. In addition, new goals, objectives, and/or target behaviors should be added as indicated. Include how progress related towards transition or discharge plan. Graphs should be included to provide visual documentation of the member's progress. **Treatment planning** is an expected part of member care. A minimum of one (1) hour treatment planning per month is required, up to one (1) hour for every 10 hours of direct service.

    a. Submission of the treatment plan is expected at least 10 days prior to the next review date. Treatment plan updates that are not sent by the end of the authorization may result in claims being denied due to lack of an active authorization on file.

16. Documentation of the following information is always important, and is essential when a member has made slow or no progress in the acquisition, maintenance and generalization of target skills.

    a. Assessments completed as frequently as necessary to determine the relationship between environmental events and behaviors.

    b. Behavior support/maintenance plan noting changes based on ongoing assessments.

    c. Observe the member's behaviors to determine effectiveness of the behavior support/maintenance plan and, if not effective, note changes to the plan.

IV. What is Not Covered

A. The following do not meet the medical necessity guidelines, and therefore coverage will not be authorized:

1. Therapy when measurable functional improvement is not expected or progress has plateaued.

[1] According to New Hampshire law RSA 417 E:2(IV), an insurer may require an updated treatment plan no more frequently than on a semi-annual basis.

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2. Services that are primarily educational in nature.

3. Under Massachusetts law, services encountered in school settings (e.g. psychosocial speech delay, behavioral problems, attention disorders, conceptual handicap, mental retardation, developmental delays). "Services related to autism spectrum disorder provided by school personnel pursuant to an individual education program are not subject to reimbursement"[2] Similarly, under New Hampshire law, carriers do not have to provide coverage for individual under an individualized family service plan or an individualized education program, as required under the federal Individuals With Disabilities Education Act, the state children's health insurance program authorized by 42 U.S.C. section 1397aa et seq., or the provision of services to an individual under any other federal or state law—it is the responsibility of the school. [3]

4. Services that are not medically necessary.

5. Treatment whose purpose is vocationally or recreationally based.

6. Treatment that is investigational or unproven, including, but not limited to facilitated communication, Auditory Integration Therapy (AIT), Holding Therapy, Higashi (Daily Life Therapy).

7. Services that are provided for developmental purposes. For the purposes of this guideline the term developmental is defined as "a delay in the expected achievement of age-appropriate fine motor, gross motor, social, or language milestones that is not caused by an underlying medical illness or condition."

8. Cognitive Therapy or retraining.

9. Personal training, life coaching

10. Custodial Care. For the purposes of this guideline custodial care is "care, administered by trained personnel, to whom the member shows no beneficial response despite extended and/or repeated treatment trials."

[2] MGL 176B Section 4DD
[3] RSA 417-E:2

REFERENCES

NCQA Standard, UM 2, Clinical Criteria for Utilization Management Decisions, Element A

Chapter 207 of the Acts of 2010 - An Act Relative to Insurance Coverage for Autism

NH RSA 417-E:1(III)(h) Coverage for Certain Biologically-Based Mental Illnesses:

NH RSA 417-E:2 Coverage for Treatment of Pervasive Developmental Disorder or Autism

NH 420-B:8-b Health Maintenance Organization Benefits for Mental and Nervous Conditions and Treatment for Chemical Dependency

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