



BlueCross BlueShield
of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

Applied Behavior Analysis (ABA) Corporate Medical Policy

File Name: Applied Behavior Analysis (ABA)

File Code: 3.01.VT201

Origination: 07/2011

Last Review: 07/2021

Next Review: 07/2022

Effective Date: 10/01/2021

Description/Summary

Autism Spectrum Disorder

Autism Spectrum Disorder (ASD) is characterized as persistent deficits in social communication and social interaction across multiple contexts, not accounted for by general developmental delay, and manifest in the following symptoms:

- Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social cues and interactions.
- Deficits in non-verbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and non-verbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and non-verbal communication.
- Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

Severity is based on social communication impairments and restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive):

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal non-verbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route).
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g.,

strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interest).

4. Hyper- or hypo-reactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

Symptoms must be present in the early developmental period, but they may not become fully manifest until social demands exceed limited capacities, or they may be masked by learned strategies in later life. The symptoms must cause clinically significant impairment in social, occupational, or other important areas of current functioning, and these impairments or disturbances must not be better explained by intellectual disability or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for the patient’s general developmental level.

Note: Individuals who have marked deficits in social communication, but whose symptoms don’t otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder.

SEVERITY LEVELS FOR AUTISM SPECTRUM DISORDER (ASD) (According to DSM 5)

Severity Level	Social Communication	Restricted, repetitive behaviors
Level 3 - Severe “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.	Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.
Level 2 - Moderate “Requiring substantial support”	Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others.	Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.
Level 1 - Mild “Requiring support”	Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social	Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of

	interactions, and clear examples of atypical or unsuccessful response to social overtures of others. May appear to have decreased interest in social interactions.	organization and planning hamper independence
--	--	---

APPLIED BEHAVIOR ANALYSIS FOR TREATMENT OF ASD

Applied behavior analysis (ABA) is an empirically developed assessment program for determining environmental variables which mediate behavior, and then developing a behavioral modification program to promote pro-social and encourage safe, non-injurious, behaviors. An individualized ABA treatment plan is developed using functional behavior analysis, by observing and measuring antecedents, behaviors, and consequences, and then creating interventions with a focus on environmental changes to promote more adaptive social behaviors. These interventions are administered very consistently, based on the protocols developed. Protocols are then modified based upon accurate quantification of changes in the identified behaviors.

According to the National Institute of Child Health and Human Development, currently there is no definitive, single treatment for the management of ASD. Individuals with ASD have a wide spectrum of behaviors and abilities so that no one approach is equally effective for all, and not all individuals in outcome studies have benefited to the same degree. In addition, individuals with ASD may require new and/or multiple episodes of care or modifications to the frequency and duration of existing services. These changes are typically based on re-examination due to the severity of the current condition, as well as changes related to growth and development, caregivers, environment, or functional demands. The primary goals of management of ASD are to minimize the core features and associated deficits, maximize functional independence and quality of life, and alleviate family distress (Myers et al, 2007). Early Intensive Behavioral Interventions (including ABA) have not been as well studied in children with early childhood developmental disorders other than ASD. However, considering the significant comorbidity of moderate and severe intellectual disabilities with ASD, it is possible that ABA will be somewhat effective in individuals in this population, even without the diagnosis of ASD.

INTELLECTUAL DISABILITY

Intellectual disability refers to deficits in intellectual and adaptive functioning, which is observed during development. Intellectual functioning includes the ability to reason, problem solve, plan, think abstractly, exercise judgement, and learn. Adaptive functioning refers to the skills needed to live in an independent and responsible manner, including communication, social skills, and self-help skills, such as dressing, feeding, money management, and shopping.

SEVERITY LEVELS	Indications
Level 4 - Profound	<ul style="list-style-type: none"> • IQ less than 20 • Significant developmental delays in all areas • Obvious physical and congenital abnormalities • Requires direct supervision

Level 3 - Severe	<ul style="list-style-type: none"> • IQ of 20-34 • Considerable delays in development • Understands speech, but little ability to communicate • Able to learn daily routines • May learn very simple self-care • Needs direct supervision in social situations
Level 2 - Moderate	<ul style="list-style-type: none"> • IQ of 35-49 • Noticeable developmental delays (i.e., speech, motor skills) • May have physical signs of impairment (i.e., thick tongue) • Can communicate in basic, simple ways • Able to learn basic health and safety skills • Can complete self-care activities • Can travel alone to nearby, familiar places
Level 1 - Mild	<ul style="list-style-type: none"> • IQ of 50 - 70 • Slower than typical in all developmental areas • No unusual physical characteristics • Able to learn practical life skills • Attains reading and math skills up to grade levels 3 to 6 • Able to blend in socially • Functions in daily life

This policy does not cover the diagnosis of mild intellectual disability (without ASD), as these individuals often possess sufficient social skills and language skills to respond to less intensive operant conditioning behavioral strategies and likely do not require ABA.

Policy

Coding Information

Click the links below for attachments, coding tables & instruction

[Attachment I- CPT® Code List & Instructions](#)

[Attachment II- ICD-10-CM Code List & Instructions](#)

[Attachment III - Applied Behavior Analysis Treatment Recommendations Worksheet](#)

The intent of this policy is to communicate the medical necessity criteria for Applied Behavior Analysis (ABA) in children diagnosed with ASD and/or moderate or severe intellectual disability for members, beginning at birth and continuing until the member reaches age 21 in accordance with Vermont state law and as outlined in the members' certificate of coverage.

INITIAL BEHAVIOR IDENTIFICATION ASSESSMENT

Prior authorization (PA) is **not required** for the initial behavior identification assessment. However, this assessment **MUST** be completed prior to requesting authorization for ABA services. The report generated from the initial behavior identification assessment must contain the following elements:

- Documented attempt to obtain records from any prior ASD evaluations and/or treatments; **AND**
- Documentation from the primary care provider, psychiatrist, or psychologist that the patient is on the autism spectrum or is diagnosed with moderate or severe intellectual disability based on the criteria set forth in DSM-5 (see Attachment II for applicable ICD-10 diagnosis codes); **AND**
- If the diagnosis is Intellectual Disability, the findings of an official psychologist's report stating that the patient has Moderate or Severe Intellectual Disability, including standardized intelligence testing conducted to determine the level of intellectual disability; **AND**
- An assessment of the severity of the Autism Spectrum Disorder according to DSM-5; **AND**
- The evaluation needs to include a completed Barriers section of the **The Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP)**
- A descriptive functional behavioral analysis is produced, with at least three focused behavior goals to be tracked, and the preliminary intervention/treatment plan
- The social/educational supports that the member is currently receiving (such as a one- on-one aide in school), as well as verification of a current Individualized Education Program (IEP). Without this required brief summary of services provided at the school, BCBSVT will be unable to provide benefits for ABA treatment in settings outside of school, as coordination of behavioral plans between school and other settings is critical to the success of any behavioral treatment.

Parts of the evaluation may be conducted by a Board Certified Assistant Behavior Analyst (BCaBA), but the evaluation must be reviewed by the Board Certified Behavior Analyst (BCBA). See provider clarification below.

PROVIDER CLARIFICATIONS FOR ABA SERVICES

ABA services are either provided by, or are performed under the supervision of, a clinician (often referred to as the program manager or lead behavioral therapist) who is one of the following:

- A Board-Certified Behavior Analyst (BCBA), certified by the Behavior Analyst Certification Board, and state-licensed and/or state-certified where required.
- Any other state-licensed or certified behavior instructor (BI)
- Any other provider whose legally permitted scope of practice includes behavior analysis.

Note: A Board-Certified assistant Behavior Analyst (BCaBA) or a state-licensed Assistant Behavior Analyst may not function as a program manager or lead behavioral therapist and may not provide ABA services without supervision.

ABA treatment is considered medically necessary when the following criteria have been identified and documented:

For members, beginning at birth and continuing until member reaches age 21

1. The member has been diagnosed with Autism Spectrum Disorder and/or moderate or severe intellectual disability by a psychiatrist, psychologist, neurologist or developmental pediatrician which has been validated by a documented assessment using DSM-5 criteria.
2. Less intensive behavioral treatment/therapy has been considered or has been ineffective.
3. ASD and/or moderate or severe ID is adversely affecting the member's development, communication, social interactions, or behavior such that the member is unable to adequately participate in age-appropriate home, school, or community activities, or the member is a safety risk to self, others, or property.
4. A descriptive functional behavioral analysis is produced, with at least three focused behavior goals to be tracked, and the preliminary interventions to be implemented.
5. All behaviors that jeopardize the child's personal safety or the safety of others in the child's environment, must have a focused intervention plan outlined and be identified as a focused behavioral goal to be tracked and charted on a graph.
6. The school/educational setting has been contacted in order to determine services provided in the school setting and to coordinate care.
7. An individualized treatment plan has been developed and includes the following elements:
 - Identification and detailed description of targeted symptoms and behaviors. Targeted symptoms and behaviors must be those which are preventing the member from adequately participating in age appropriate home, school or community activities, or that are presenting a safety risk to self, others or property;
 - Individualized goals which are developed taking into consideration the member's age, adaptive functioning, and intellectual functioning; with estimated timeframes for achieving the goals.
 - Goals should be prioritized based on implications for the member's health and well-being, the impact on member, family and community safety, and contribution to member's functional independence;
 - Measurable objectives based on clinical observation and assessment of outcome measures;
 - Objective baseline measurements of each targeted symptom and behavior;
 - Description of treatment modality or modalities and intervention for each targeted symptom and behavior;
 - Inclusion of parents (or active caretakers or legal guardians when appropriate); specifically, goals and detailed description of interventions with parents, including,

- as appropriate, parental education, training, coaching, support, overall goals for parents, and plan for transferring interventions with member/identified patient to parents;
- Care coordination which includes the member's family and other community support care givers, school, mental health providers, medical providers, and any other applicable parties;
 - Service setting and hours of treatment;
 - Interventions emphasizing generalization of skills and focus on the development of spontaneous social communication, adaptive skills, and appropriate behaviors; and
 - Measurable criteria for completing treatment, with projected plan for continued care after discharge from ABA.
8. Hours requested for treatment per service are listed and are within the parameters set forth in this policy (see coding table below for maximum units/hours allowed for each service type);
 9. ABA hours provided per this policy will be for time of treatment outside of the school setting (i.e., home or office setting), so that the school is responsible for ABA provided by an aide throughout the school day. For example, if direct 1:1 ABA service is approved by BCBSVT, it is likely that the member would benefit from ABA being provided in the school setting as well.
 10. For continued ABA services beyond the initial six-month authorization period, continued care criteria for medical necessity must be met as indicated below. **Prior authorization is required for each six-month period.**

When a service may be considered medically necessary

1. ABA treatment plans are reviewed by a BCBA quarterly and any time there is a significant change in the treatment plan;
2. The member continues to meet criteria defined in the above section (ABA medical necessity criteria);
3. Evaluation of progress, including data on targeted symptoms and behaviors is collected by direct therapy providers. The program manager/lead behavioral therapist evaluates the data from all sessions and summarizes progress on each targeted symptom and behavior at least once every six (6) months. Evaluations must include the following elements:
 - Progress is assessed and documented for each targeted symptom and behavior, including progress toward the defined goals and including the same models of measurement that were utilized for baseline measurements of specific symptoms and behaviors;
 - When goals have been achieved, either new goals should be identified or the treatment plan should be revised to include a transition to less intensive interventions;
 - When there has been inadequate progress or no progress demonstrated within a six (6) month period, or specific goals have not been achieved within the estimated timeframes, there should be an assessment of the reasons for the lack of progress or

goals being unmet and treatment interventions should be modified or changed in order to attempt to achieve adequate progress.

4. Treatment does not appear to be negatively impacting the member or causing symptoms to become persistently worse;
5. The member continues to achieve treatment goals;
6. The member continues to demonstrate progress towards goals over successive authorization periods as indicated below*. If progress towards treatment goals is not being demonstrated, there must be evidence that the treatment plan is being adjusted; and
7. The member demonstrates the ability to maintain long-term gains from the proposed plan of treatment.

*Continued ABA services are medically necessary when the following expected improvements are documented; targeted behaviors are graphed and a VB-MAPP Transition Scoring Form is completed (Improvements are from baseline to specific endpoint as indicated):

- Five to six months from baseline:
 - There is at least a 20 percent decline in negative (“exposure ABA”) behaviors from the first month of collecting data, as evidenced by focused goal graph charting, and/or
 - There is at least a 20 percent increase in positive (“adaptive ABA”) behaviors from the first month of collecting data, as evidenced by focused goal graph charting.
- Eleven to twelve months from baseline:
 - There is at least a 40 percent decline in negative (“exposure ABA”) behaviors from the first month of collecting data, as evidenced by focused goal graph charting, and/or
 - There is at least a 40 percent increase in positive (“adaptive ABA”) behaviors from the first month of collecting data, as evidenced by focused goal graph charting.
- Seventeen to Eighteen months and beyond from baseline:
 - There is at least a 75 percent decline in negative (“exposure ABA”) behaviors from the first month of collecting data, as evidenced by focused goal graph charting, and/or
 - There is at least a 75 percent increase in positive (“adaptive ABA”) behaviors from the first month of collecting data, as evidenced by focused goal graph charting.

When a service is considered not medically necessary

1. The member reaches 21 years of age.
2. Treatment is making the symptoms or negative behavior(s) persistently worse.

3. No meaningful, measurable change has been documented in the individual's functioning and/or behavior(s) for a period of at least six months of optimal treatment.
4. The individual has achieved adequate stabilization of functions and/or the challenging behavior(s), and less-intensive modes of treatment are appropriate. (It is appropriate to request to restart treatment if measurable deterioration in functioning and/or behavior(s) occurs with less intensive modes of treatment).
5. The individual's parent(s) and/or caregiver(s) demonstrate adequate skill in administering a long-term home-based program.
6. The individual demonstrates an inability to maintain long-term gains from the proposed treatment plan.

When a service is considered a benefit exclusion and therefore not covered

1. Services beyond those needed to restore the ability to perform Activities of Daily Living or to establish or re-establish the capability to perform occupational, hobby, sport or leisure activities.
2. Care for which there is no therapeutic benefit or likelihood of improvement.
3. Education, educational evaluation or therapy, therapeutic boarding schools, services that should be covered as part of an evaluation for, or inclusion in, a child's individualized education plan (IEP) or other educational program.
4. Support therapies, including pastoral counseling, assertiveness training, dream therapy, hippotherapy, music or art therapy, recreational therapy, tobacco cessation support therapy, stress management, wilderness programs, therapy camps, adventure therapy and bright light therapy.

REQUIRED DOCUMENTATION

When requesting prior authorization for **initial ABA services**, you must submit a completed **State of Vermont Uniform Medical Prior Authorization Form** along with the following required documentation:

- Completed initial assessment report containing the elements described above
- A summary of the services being provided in the educational setting. If there are no services being provided in the educational setting, a detailed description of why services are not provided in that setting, including whether a formal request was made by the parent/guardian of the member
- Completed Individualized Treatment Plan (see above for treatment plan requirements)
- Completed ABA Treatment Recommendations Worksheet indicating appropriate CPT[®] codes and hours requested (see Attachment III)

When requesting prior authorization for **each additional 6 months** of ABA services, you must submit the following documentation:

- You must submit a new completed State of Vermont Uniform Medical Prior Authorization Form within 30 days of the end date of the previous authorization period
- Supporting documentation needs to include: graphs of focused negative behavior goals (“exposure ABA” behaviors) and focused positive behavior goals (“adaptive ABA” behaviors), with at least monthly intervals (on the x axis)
- A summary of the services being provided in the educational setting. If there are no services being provided in the educational setting, a detailed description of why services are not provided in that setting, including whether a formal request was made by the parent/guardian of the member
- A summary of parent training progress
- A completed VB-MAPP Transition Scoring Form. For children greater than 48 months old, the VB-MAPP Milestones Assessment Score may be omitted from the Transition Scoring Form if it is felt to be inappropriate for the developmental level of the member (please note as such); if the member is greater than 48 months old, and he/she is diagnosed with ASD, Level 1 by DSM-5 criteria, then he/she will likely not be appropriate for the VB-MAPP Milestones Assessment Score.
- An updated Treatment Plan (if changes are made to the treatment plan)
- Completed ABA Treatment Recommendations Worksheet indicating appropriate CPT® codes and hours requested (see Attachment III).

Reference Resources

1. American Academy of Neurology (AAN) and the Child Neurology Society. Practice parameter: Screening and diagnosis of autism. August 2000. Available at the American Academy of Neurology website. Accessed May 2014.
2. American Academy of Pediatrics (AAP). Auditory integration training and facilitated communication for autism. Original: August 1998. (Reaffirmed: 05/01/06). Available at the American Academy of Pediatrics website. Accessed May 2014.
3. American Academy of Pediatrics (AAP). Management of Children with Autism Spectrum Disorders. May 2007. Available at: the American Academy of Pediatrics website. Accessed May 2014.
4. Autism Speaks, Inc. (2017). *AutismSpeaks.org*. Retrieved from www.autismspeaks.org
5. American Academy of Pediatrics (AAP). The AAP Autism Screening Guidelines: Integrating Screening Guidelines in Primary Care Practice. January 2011. Available at: the American

- Academy of Pediatrics website. Accessed May 2014.
6. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition (DSM-5). 5th ed. American Psychiatric Publishing, Inc.; 2013.
 7. Behavior Analyst Certification Board (BACB). About BACB Credentials. 2009. Available at: Board Certified Behavior Analysis website. Accessed May 2014.
 8. Behavior Analyst Certification Board (BACB). Health Plan Coverage of Applied Behavior Analysis Treatment for Autism Spectrum Disorder v1.1. 2012.
 9. Centers for Disease Control and Prevention (CDC). Autism Spectrum Disorder (ASD) Data and Statistics. 2010 data. Available at: Center for Disease Control and Prevention website. Accessed September 2014.
 10. Dawson G, Rogers S, et al. Randomized, controlled trial of an intervention for toddlers with autism: The Early Start Denver Model. *Pediatrics*. 2010; 51 (10): 1052-65.
 11. Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD). Intellectual and developmental disabilities (IDDs): For Researchers and Health Care Providers. Available at the Eunice Kennedy Shriver National Institute of Child Health and Human Development. Accessed May 2014.
 12. National Conference of State Legislatures (NCSL). NCSL autism legislation database. Available at the National Conference of State Legislatures (NCLS) website. Accessed May 2014.
 13. Peters-Scheffer, Didden R, et al. A meta-analytic study on the effectiveness of comprehensive ABA-based early intervention programs for children with Autism Spectrum Disorders. *Research in Autism Spectrum Disorders*. 2011; 5: 60-69.
 14. Premera Blue Cross. (2017, April 1). Applied Behavior Analysis. Medical Policy No. 3.01.510.
 15. Reichow B, Barton EE, The Cochrane Collaboration. Early intensive behavioral intervention for young children with autism spectrum disorders (ASD) (Review). *The Cochrane Library*. 2012: Issue 10.
 16. Spreckley M, Boyd R. Efficacy applied behavioral intervention in preschool children with autism for improving cognitive, language and adaptive behavior: a systematic review and meta-analysis. *Journal of Pediatrics*. 2009; 154 (3): 338-44.
 17. Sundberg ML. Verbal Behavioral Milestones Assessment and Placement Program (VB-MAPP) Guide. AVB Press. 2014.
 18. Volkmar F, Siegel M, American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CGI), Practice Parameter for the Assessment and Treatment of Children and Adolescents with Autism Spectrum Disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2014; 53 (2): 237-257.
 19. Wolstencroft J, Robinson L et al. A systematic review of group social skills interventions, and meta-analysis of outcomes, for children with high functioning ASD. *J Autism and Dev Disorders* 2018. 48 July: 2293-2307.
 20. 8.V.S.A.§4088i. Available at: <https://law.justia.com/codes/vermont/2012/title08/chapter107/section4088i/>. Accessed 22 July 2021.

Document Precedence

Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer's benefit plan if an

ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non-compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval may be required and benefits are subject to all terms, limitations and conditions of the subscriber contract.

Incomplete authorization requests may result in a delay of decision pending submission of missing information. To be considered complete, see policy guidelines above.

NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member's health plan.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

In order to obtain prior authorization use the Prior Authorization/Pre-Certification form available at the BCBSVT provider portal and fax your request to the integrated health management department at (866) 387-7914. Failure to obtain prior authorization may result in a denial of benefits. **NOTE:** Prior authorization is not required for the initial screening and/or diagnostic assessments for ASD and/or moderate or severe ID.

Policy Implementation/Update information

07/2011	New Policy
11/2013	ICD-10 remediated. Age requirement changed to: up to 21 years. Non-covered section (including exclusions) added pg.14.
02/2015	Cat III codes and clinical criteria for ABA services added. Diagnosis codes for Moderate and Severe intellectual disability added. Clarification on Genetic Testing added. Reviewed & approved by MPC Jan. 2015.
09/2018	<ol style="list-style-type: none"> 1. Title changed to “Applied Behavior Analysis (ABA)” 2. All sections of policy not specific to ABA were removed 3. Updated descriptions of Autism Spectrum Disorder (ASD) and Intellectual Disability to align with ICD-10 / DSM 5 4. Removed section on screening and evaluation of ASD 5. Updated section on requirements of initial Behavior Identification Assessment 6. Updated medical necessity criteria for initial ABA and continuation of ABA services; align with State of VT guidelines 7. Added section listing required documents to be submitted with prior authorization request for initial ABA services and for continued ABA services 8. Changed number of allowable units for each procedure code 9. Updated procedure code list, diagnosis codes (Attachments I and II) 10. Added Attachment III (Treatment Recommendations Worksheet) <p>Coding reviewed all codes and codes removed have been reconciled to be aligned with appropriate policies. The codes presented in this policy (0360T, 0361T, 0362T, 0363T, 0364T, 0365T, 0368T, 0369T, 0370T, 0371T, 0373T, 0374T) require PA. ICD 9-CM table removed and updated with ICD-10 -CM table</p>
01/2019	Effective 01/01/2019 Adaptive Maintenance Review with the following changes: Summary of changes effective 01/01/2019: The following codes have been Deleted Codes: 0359T, 0360T, 0361T, 0363T, 0364T, 0365T, 0366T, 0367T, 0368T, 0369T, 0370T, 0371T, 0372T, 0374T. Revised codes: 0362T & 0373T. New Codes: 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158.

01/2019	Coding Summary: Revised the following on Attachment III: Updated the codes 0362T & 0373T descriptors effective 01/01/2019. Added codes 97154 & 97158 effective 01/01/2019 to the worksheet. Revised language under Applied Behavior analysis for Treatment of ASD section. Updated references.
05/2019	Updated the maximum hours/ units allowed for code 97155. Updated references.
07/2021	Revised Autism Spectrum Services for members, beginning at birth and continuing until the member reaches age 21. Updated reference.

Eligible providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by BCBSVT Medical Directors

Date Approved

Joshua Plavin, MD, MPH, MBA
Chief Medical Officer

Kate McIntosh, MD, MBA, FAAP
Senior Medical Director

Attachment I
CPT® Code List & Instructions

Code	Description	Policy Instructions						
The following codes will be considered as medically necessary when applicable criteria have been met.								
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.	<p>Prior approval required; maximum of 30 hours (120 units) per 6-month period.</p> <p>Used for follow-up assessments (supervision services); exposure</p>						
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	<p>Prior approval required; maximum hours allowed as follows:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center; width: 30%;">< 3 years old</td> <td>Maximum 78 hours (312 units) per 6-month period</td> </tr> <tr> <td style="text-align: center;">3-5 years old</td> <td>Maximum 65 hours (260 units) per 6-month period</td> </tr> <tr> <td style="text-align: center;">> 5 years old</td> <td>Maximum 39 hours (156 units) per 6-month period</td> </tr> </table> <p>Used for ABA therapy services; exposure, modified.</p>	< 3 years old	Maximum 78 hours (312 units) per 6-month period	3-5 years old	Maximum 65 hours (260 units) per 6-month period	> 5 years old	Maximum 39 hours (156 units) per 6-month period
< 3 years old	Maximum 78 hours (312 units) per 6-month period							
3-5 years old	Maximum 65 hours (260 units) per 6-month period							
> 5 years old	Maximum 39 hours (156 units) per 6-month period							
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	<p>Prior approval is not required.</p>						

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	<p>Prior approval required; maximum of 30 hours (120 units) per 6-month period</p> <p>Used for follow-up assessments (supervision services); observational/adaptive</p>						
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	<p>Prior approval required; maximum hours allowed as follows:</p> <table border="1" data-bbox="1251 396 2058 505"> <tr> <td data-bbox="1251 396 1457 428">< 3 years old</td> <td data-bbox="1457 396 2058 428">Maximum 780 hours (3,120 units) per 6-month period</td> </tr> <tr> <td data-bbox="1251 428 1457 461">3-5 years old</td> <td data-bbox="1457 428 2058 461">Maximum 650 hours (2,600 units) per 6-month period</td> </tr> <tr> <td data-bbox="1251 461 1457 505">> 5 years old</td> <td data-bbox="1457 461 2058 505">Maximum 390 hours (1,560 units) per 6-month period</td> </tr> </table> <p>Used for ABA therapy services; adaptive.</p>	< 3 years old	Maximum 780 hours (3,120 units) per 6-month period	3-5 years old	Maximum 650 hours (2,600 units) per 6-month period	> 5 years old	Maximum 390 hours (1,560 units) per 6-month period
< 3 years old	Maximum 780 hours (3,120 units) per 6-month period							
3-5 years old	Maximum 650 hours (2,600 units) per 6-month period							
> 5 years old	Maximum 390 hours (1,560 units) per 6-month period							
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	<p>Prior approval required; maximum 36 hours (144 units) per 6-month period of 97154 and 97158 combined.</p> <p>Used for multi-patient group therapy by technician.</p>						
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	<p>Prior approval required; maximum hours allowed as follows:</p> <table border="1" data-bbox="1251 808 2058 917"> <tr> <td data-bbox="1251 808 1457 841">< 3 years old</td> <td data-bbox="1457 808 2058 841">Maximum 156 hours (1248 units) per 6-month period</td> </tr> <tr> <td data-bbox="1251 841 1457 873">3-5 years old</td> <td data-bbox="1457 841 2058 873">Maximum 130 hours (520 units) per 6-month period</td> </tr> <tr> <td data-bbox="1251 873 1457 917">> 5 years old</td> <td data-bbox="1457 873 2058 917">Maximum 78 hours (312 units) per 6-month period</td> </tr> </table> <p>Used for ABA therapy services; adaptive, modified.</p>	< 3 years old	Maximum 156 hours (1248 units) per 6-month period	3-5 years old	Maximum 130 hours (520 units) per 6-month period	> 5 years old	Maximum 78 hours (312 units) per 6-month period
< 3 years old	Maximum 156 hours (1248 units) per 6-month period							
3-5 years old	Maximum 130 hours (520 units) per 6-month period							
> 5 years old	Maximum 78 hours (312 units) per 6-month period							
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	<p>Prior approval required; maximum 26 hours (104 units) per 6-month period.</p> <p>Used for family adaptive therapy.</p>						
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	<p>Prior approval required; maximum 26 hours (104 units) per 6-month period.</p> <p>Used for multi-family group therapy, without the patient present.</p>						

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	<p>Prior approval required; maximum 36 hours (144 units) per 6-month period of 97154 and 97158 combined.</p> <p>Used for multi-patient group therapy by physician or QHCP.</p>
-------	---	---

Attachment II
ICD-10-CM Code List & Instructions

Code Type	Number	Description	
The following diagnosis codes will be considered as medically necessary when applicable criteria have been met.			
ICD-10-CM	F71	Intellectual Disability- Moderate	
ICD-10-CM	F72	Intellectual Disability- Severe	
ICD-10-CM	F84.0	Autistic Disorder	
ICD-10-CM	F84.2	Rett's Syndrome	
ICD-10-CM	F84.3	Other Childhood Disintegrative Disorder	
ICD-10-CM	F84.5	Asperger's Syndrome	
ICD-10-CM	F84.8	Other Pervasive Developmental Disorders	
ICD-10-CM	F84.9	Pervasive Developmental Disorder, Unspecified	

Attachment III
Applied Behavior Analysis Treatment Recommendations Worksheet

Please circle each code being requested and indicate number of hours and/or units requested for each circled code.

CODES	Service Description	Hours/units requested (per 6-month period)	Additional Notes
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		
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		
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		