Regence

Medical Policy Manual Behavioral Health, Policy No. 33

Applied Behavior Analysis Initial Assessment for the Treatment of Autism Spectrum Disorder

Effective: November 1, 2024

Next Review: April 2025
Last Review: June 2024

IMPORTANT REMINDER

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

DESCRIPTION

Applied Behavior Analysis (ABA) is an umbrella term describing principles and techniques used in the assessment, treatment, and prevention of challenging behaviors and the promotion of new desired behaviors. An initial assessment is completed before the initiation of ABA-based therapy.

MEDICAL POLICY CRITERIA

Note: This policy only applies to member contracts that are subject to preauthorization for the initial assessment for Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder, as specified by their group plan. Please check the preauthorization website for the member contract to confirm requirements.

I. An Applied Behavior Analysis (ABA)-based therapy initial assessment may be considered **medically necessary** when all of the following criteria (A.-C.) are met:

   A. The member has been diagnosed with Autism Spectrum Disorder by a qualified treating health care professional (e.g. pediatrician, pediatric neurologist,

developmental pediatrician, psychologist), as defined by state law; and

B. The Autism Spectrum Disorder (ASD) related symptoms and behaviors are impairing the member's communication, social and/or behavioral functioning such that the member is a safety risk to self or others and/or is unable to participate in age-appropriate home or community activities; and

C. ABA therapy must be recommended or prescribed by a qualified treating health care professional (e.g. pediatrician, pediatric neurologist, developmental pediatrician, psychologist) experienced in the diagnosis and treatment of autism, as defined by state law.

II. An Applied Behavior Analysis (ABA)-based therapy initial assessment is considered **not medically necessary** when the above criteria are not met.

NOTE: A summary of the supporting rationale for the policy criteria is at the end of the policy.

POLICY GUIDELINES

APPLICABLE BENEFITS

This policy applies to member contracts with applicable benefits subject to the following:

- Washington's Mental Health Parity Act (RCW 48.44); or
- Oregon's Mental Health Parity Act (ORS 743.168) effective August 8, 2014; or
- Idaho's Clarification Regarding Coverage of Treatments for Autism Spectrum Disorder (Bulletin No. 18-02), or
- Utah's Autism Services Amendment, SB 57 (UCA 31A-22-642) effective 2016.

CERTIFIED PROVIDERS

Treating providers who are certified to provide ABA therapy include a qualified Lead Behavior Analysis Therapist (LBAT), and in Idaho, a credentialed provider with a Board-Certified Behavioral Analysis (BCBA) certification issued by the Behavioral Analyst Certification Board.

LIST OF INFORMATION NEEDED FOR REVIEW

REQUIRED DOCUMENTATION:

The following information may be required for review of the ABA initial assessment:

Assessment

- Documentation of the following from the qualified treating healthcare professional (Criteria I.A. and B., above):
  - Diagnosis of Autism Spectrum Disorder (ASD)
  - ASD is impairing the member's functioning such that the member is a safety risk and/or is unable to participate in age-appropriate activities
- Written recommendation, clinical order, or prescription for ABA services from the provider (Criterion I.C., above)

CROSS REFERENCES

1. Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder, Behavioral Health, Policy No. 18

BACKGROUND

AUTISM SPECTRUM DISORDER

Autism Spectrum Disorder (ASD) is a neurodevelopment disorder characterized by impaired social communication and interaction and atypical interests and behavioral patterns. ASD may be accompanied by other conditions, such as epilepsy and cognitive impairment. As defined by the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, (DSM-5),[1] ASD includes:

- Autistic Disorder
- Asperger's Disorder
- Pervasive Developmental Disorder, Not Otherwise Specified (PDD-NOS)

Diagnostic criteria for ASD as defined by the DSM-5[1] are listed in Appendix 1.

BEHAVIORAL INTERVENTIONS FOR AUTISM SPECTRUM DISORDER

A number of behavioral interventions (e.g., educational, medical, behavioral, complementary, and other allied health interventions) aiming to improve core social, communication and challenging behaviors are available. Several treatments for ASD have been developed based upon different treatment principles, such as applied behavior analysis (ABA) as described below. With the exception of two treatment therapies (UCLA/Lovaas and Early Start Denver Model), most ABA intervention protocols have not been manualized, resulting in the potential for practice and treatment variation.

Applied Behavior Analysis

ABA may be defined as: "the design, implementation and evaluation of environmental modifications, using behavioral interventions for the treatment of autism spectrum disorder. The goal of the therapy is to produce clinically significant improvements in core deficits associated with autism spectrum disorder (i.e. significant issues with communication, social interaction or injurious behaviors). It includes the use of direct observation, measurement and functional analysis of the relationship between the environment and behavior and uses behavioral stimuli and consequences."

The majority of the research supporting the use of ABA has been conducted in children; although there is some evidence of the effectiveness of ABA in adults (18 years and older), the evidence is less robust and definitive, warranting closer review.[2, 3]

The initial assessment that occurs prior to the initiation of ABA-based therapy identifies strengths and weaknesses and potential barriers to the success of the therapy. The treatment plan is based on this initial assessment.

Early Intensive Behavioral Intervention

Early intensive behavioral interventions incorporate principles of ABA but differ in methods and settings. There are two intensive, manualized ABA-based early intervention programs intended

to improve the challenging behaviors specifically associated with ASD that include University of California, Los Angeles (UCLA/Lovaas and the Early Start Denver model).

SUMMARY

Applied Behavior Analysis (ABA) is applied in the assessment, treatment, and prevention of challenging behaviors and the promotion of new desired behaviors. This method of treatment is often used for Autism Spectrum Disorder (ASD). Individual states have mandated requirements for the assessment and treatment of ASD, which the policy criteria align with. Therefore, an ABA initial assessment may be considered medically necessary for ASD when policy criteria are met. When policy criteria are not met, an ABA initial assessment for ASD is considered not medically necessary.

REFERENCES

1. American Psychiatric Association (2013): Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Arlington VA: American Psychiatric Press.
2. Wong C, Odom SL, Hume KA, et al. Evidence-Based Practices for Children, Youth, and Young Adults with Autism Spectrum Disorder: A Comprehensive Review. *J Autism Dev Disord.* 2015;45(7):1951-66. PMID: 25578338
3. Bishop-Fitzpatrick L, Minshew NJ, Eack SM. A systematic review of psychosocial interventions for adults with autism spectrum disorders. *J Autism Dev Disord.* 2013;43(3):687-94. PMID: 22825929

CODES

Codes	Number	Description
CPT	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.
	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
HCPCS	None	

APPENDIX 1

Diagnostic and Statistical Manual of Mental Disorders, *5th Edition* *(DSM-5)*

Autism Spectrum Disorder, 299.00 (F84.0)

Diagnostic Criteria

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive, see text):

1. 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 interactions.
2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal 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 nonverbal communication.
3. 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.

Specify current severity:

Severity is based on social communication impairments and restricted repetitive patterns of behavior (see Table 1).

B. 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; see text):

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 nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat food every day).
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 hyporeactivity 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).

Specify current severity:

Severity is based on social communication impairments and restricted, repetitive patterns of behavior (see Table 1).

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) 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 general developmental level.

Note: Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder.

Specify if:

With or without accompanying intellectual impairment

With or without accompanying language impairment

Associated with a known medical or genetic condition or environmental factor

Table 1. Severity levels for autism spectrum disorder

Severity level	Social communication	Restricted, repetitive behaviors
Level 3 "Requiring very substantial support"	Severe deficits in verbal and nonverbal social communizations skills cause severe impairment sin 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 or 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 changing focus or action.
Level 2 "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. For example, a person who speaks simple sentences, whose interaction is limited to narrow	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.

	special interests, and who has markedly odd nonverbal communication.	Distress and/or difficulty changing focus or action.
Level 1 “Requiring support”	Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions. For example, a person who is able to speak in full sentences and engages in communication but whose to-and-fro conversation with other fails, and whose attempts to make friends are odd and typically unsuccessful.	Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

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