# Medical Necessity Guidelines: ABA (Applied Behavior Analysis) Therapy for Autism Spectrum Disorders for MassHealth Members

*Effective: October 16, 2019*

| **Prior Authorization Required**<br>If REQUIRED, submit supporting clinical documentation pertinent to service request. | **Yes ☒ No ☐** |
|---|---|

**Applies to:**
**COMMERCIAL Products**

☐Tufts Health Plan Commercial products; Fax: 617.972.9409

☐Tufts Health Freedom Plan products; Fax: 617.972.9409

- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

**TUFTS HEALTH PUBLIC PLANS Products**

☐Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055

☒Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055

☐Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404

☐Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 781.393.2607

*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

**SENIOR Products**

- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List
- Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

**Note:** While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

## OVERVIEW

Autism spectrum disorders (ASD) are a group of neurodevelopmental disorders characterized by difficulties in social interaction, impaired communication (both verbal and nonverbal), and repetitive, restrictive behaviors that present in early childhood. ASD has heterogeneous etiology and comorbidities. Diagnostic criteria and nomenclature for these disorders has changed over the years and, while the current terminology in the Diagnostic and Statistical Manual 5 (DSM 5) uses a single category called Autism Spectrum Disorders, previous versions divided this into multiple subcategories.

Applied Behavioral Analysis (ABA) services are defined according to the Behavior Analyst Certification Board as the following:

"ABA is a well-developed scientific discipline among the helping professions that focuses on the analysis, design, implementation, and evaluation of social and other environmental modifications to produce meaningful changes in human behavior. ABA includes the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. ABA uses changes in environmental events, including antecedent stimuli and consequences, to produce practical and significant changes in behavior."

Types of ABA include, but are not limited to, discrete trial training, verbal behavioral intervention, and pivot response training. Parental and caregiver involvement in the process and continued use of the strategies outside of the formal sessions is important for the success of the treatment in the long-term.

The individual ABA treatment plan is developed by a Licensed, Applied Behavior Analyst. The actual one-on-one sessions are typically provided by behavioral technicians or paraprofessionals with services ranging in hours of Member contact per week based on the severity of symptoms and intensity of treatment. The technician is supervised by the Licensed, Applied Behavior Analyst.

Treatment may be provided in a variety of settings, such as at home and in the community. ABA services covered under a health benefit plan are typically delivered by a contracted and credentialed provider in a home or community setting. Services provided in a school setting are distinct and separate from those covered by the health plan and are typically covered by the educational system's special education resources as part of the Individual Education Plan (IEP) pursuant to Public Law 94-142.

ABA is typically an extremely intensive treatment program designed to address challenging behavior as defined in our admission criteria. It can occur in any number of settings, including, home, agencies, and hospitals.

## CLINICAL COVERAGE CRITERIA

### ADMISSION CRITERIA

**All** of the following criteria are necessary for admission.

1) The Member has a definitive diagnosis of an Autism Spectrum Disorder (DSM 5) or an Autistic Disorder/Asperger's Disorder/PDD, NOS diagnosis (DSM IV).
2) The diagnosis in (1) above is made by a licensed physician or psychologist experienced in the diagnosis and treatment of autism with developmental or child /adolescent expertise.
3) The child or adolescent has received a comprehensive diagnostic and/or functional assessment (e.g. ABLLS-R, Vineland-II, ADI-R, ADOS-G, CARS2, VB-MAPP, or Autism Behavior Checklist), which include the following:
    a) Complete medical history include pre-and perinatal, medical, developmental, family, and social elements;
    b) Physical examination, which may include items such as growth parameters, head circumference, and a neurologic examination;
    c) Detailed behavioral and functional evaluation outlining the behaviors consistent with the diagnosis of ASD and its associated comorbidities. A diagnostic evaluation must include the scores from the use of formal diagnostic tests and scales as well as observation and history of behaviors. Screening scales such as the MCHAT-R are not sufficient to make a diagnosis and will not be accepted as the only formal scale; and
    d) Medical screening and testing has been completed to identify the etiology of the disorder, rule out treatable causes, and identify associated comorbidities as indicated.
4) The Member exhibits atypical or disruptive behavior that significantly interferes with daily functioning and activities or that poses a risk to the Member or others related to aggression, self-injury, property destruction, etc.
5) Initial evaluation from a Licensed Applied Behavior Analyst supports the request for the ABA services.
6) The diagnostic report clearly states the diagnosis and the evidence used to make that diagnosis.

### CONTINUING STAY CRITERIA

**All** of the following criteria are necessary for continuing treatment at this level of care.

1) The individual's condition continues to meet admission criteria for ABA, either due to continuation of presenting problems, or appearance of new problems or symptoms.
2) There is reasonable expectation that the individual will benefit from the continuation of ABA services. Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated. The treatment plan is updated based on treatment progress including the addition of new target behaviors.
3) Initial assessment from a Licensed Applied Behavior Analyst supports the request for ABA services.
4) A Member's progress is monitored regularly evidenced by behavioral graphs, progress notes, and daily session notes. The treatment plan is to be modified, if there is no measurable progress toward decreasing the frequency, intensity and/or duration of the targeted behaviors and/or increase in skills for skill acquisition to achieve targeted goals and objectives.
5) There is documented skills transfer to the individual and treatment transition planning from the beginning of treatment.
6) There is a documented active attempt at coordination of care with relevant providers/caretakers, etc., when appropriate. If coordination is not successful, the reasons are documented.
7) Parent(s) and/or guardian(s) involvement in the training of behavioral techniques must be documented in the Member's medical record and is critical to the generalization of treatment goals to the Member's environment.

8) Services are not duplicative of services that are part of an Individual Educational Plan (IEP) or Individual Service Plan (ISP) when applicable.

**DISCHARGE CRITERIA**

**Any** of the following criteria are sufficient for discharge from this level of care.

1) A Member's individual treatment plan and goals have been met.
2) The individual has achieved adequate stabilization of the challenging behavior and less-intensive modes of treatment are appropriate and indicated.
3) The individual no longer meets admission criteria, or meets criteria for a less or more intensive services.
4) Treatment is making the symptoms persistently worse.
5) The individual is not making progress toward treatment goals, as demonstrated by the absence of any documented meaningful (i.e., durable and generalized) measurable improvement or stabilization of challenging behavior and there is no reasonable expectation of progress.

## LIMITATIONS

**EXCLUSION CRITERIA**

**Any** of the following criteria are sufficient for exclusion from this level of care.

1) The individual has medical conditions or impairments that would prevent beneficial utilization of services.
2) The individual requires the 24-hour medical/nursing monitoring or procedures provided in a hospital setting.
3) The individual is receiving on going In-Home Behavioral Services or services similar to ABA
4) The following services are not included within the ABA treatment process and will not be certified:
   - vocational rehabilitation
   - supportive respite care
   - recreational therapy
   - respite care
5) The services are primarily for school or educational purposes.
6) The treatment is investigational or unproven, including, but not limited to facilitated communication, Auditory Integration Therapy (AIT), Holding Therapy, and Higashi (Daily Life Therapy).
7) Pursuant to MassHealth requirements, the individual is 19 years of age or older and enrolled in a Family Assistance plan, or 21 years of age or older and enrolled in a Standard or CommonHealth plan.

## CODES

The Member must have one of the following ICD-10 diagnoses to be considered for coverage.

**Table 1: ICD-10 Codes**

| ICD-10 Code | Description |
|---|---|
| F84.0 | Autistic disorder |
| F84.3 | Other childhood disintegrative disorder |
| F84.5 | Asperger's syndrome |
| F84.8 | Other pervasive developmental disorders |
| F84.9 | Pervasive developmental disorder, unspecified |

**Table 2: CPT Codes**

| CPT Procedure Code | Description |
|---|---|
| H0031 | Mental health assessment, by non-physician - Assessment and treatment planning by a BCBA |
| H0032 | Mental health service plan development by non-physician - Direct supervision of a paraprofessional by a BCBA |
| H2012 | Behavioral health day treatment, per hour - Direct service by a BCBA |
| H2019 | Therapeutic behavioral services, per 15 minutes - Paraprofessional direct service supervised by a BCBA |

## REFERENCES

1. MassHealth Medical Necessity Criteria "Applied Behavioral Analysis (ABA)" published August 23, 2016

## APPROVAL HISTORY

September 8, 2015: Per the request of EOHHS, MassHealth-specific ABA therapy guidelines created to mirror the guidelines for Applied Behavior Analysis (ABA) Medical Necessity Criteria (MNC). Reviewed by the Mental Health Operations and Policy Committee.

Subsequent endorsement date(s) and changes made:

- September 9, 2015: Guidelines reviewed and approved by IMPAC and effective 10/1/2015.
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- September 7, 2016: Reviewed and approved by IMPAC, effective September 12, 2016. Adopted MassHealth updated Medical Necessity Guidelines, in which board certification was added to the practitioner qualifications necessary to support the request for ABA under the Admission Criteria; and an initial assessment requirement added to Continuing Stay requirement.
- December 14, 2016: Reviewed by IMPAC, renewed without changes
- December 28, 2016: Coding updated
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- May 10, 2017: Reviewed by IMPAC. Changed "Board Certified Behavior Analyst" to "Licensed Applied Behavior Analyst." In Exclusions, removed examples of services similar to ABA, and added exclusionary language regarding ages
- November 3, 2017: Reviewed by Behavioral Health Practitioner Advisory Committee and approved without changes.
- November 8, 2017: Reviewed and approved without changes by the Integrated Medical Policy Advisory Committee.
- October 10, 2018: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC), renewed without changes
- October, 2018: Template and disclaimer updated
- October 16, 2019: Reviewed by IMPAC, renewed without changes

## BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.