Sentara Health Plans

Medicaid

# Applied Behavioral Analysis

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**All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.**

## Purpose:

This policy addresses Applied Behavioral Analysis

## Description & Definitions:

Mental Health Services (formerly CMHRS) – App. D - Intensive Community Based Support – Youth p. 31 (11/30/2021)

"Applied Behavior Analysis" or "ABA" means the practice of behavior analysis as established by the Virginia Board of Medicine in § 54.1-2900 as the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

ABA services must include the following four characteristics:

- An objective assessment and analysis of the client's condition by observing how the environment affects the client's behavior, as evidenced through appropriate data collection.
- Importance given to understanding the context of the behavior and the behavior's value to the youth, the family, and the community.
- Utilization of the principles and procedures of behavior analysis such that the client's health, independence, and quality of life are improved.
- Consistent, ongoing, objective assessment and data analysis to inform clinical decision-making.

The following required activities apply to ABA:

- An initial assessment for ABA consistent with the components required in the Comprehensive Needs Assessment (see Chapter IV for requirements), documenting the youth's diagnosis/es and describing how service needs match the level of care criteria must be completed at the start of services. The initial assessment must:
    - be completed by the LBA, LABA or LMHP acting within the scope of practice. Other qualified staff may assist with the completion of an assessment

    - be conducted in-person with the youth and the youth's family/caregivers
    - The youth has met criteria for a primary diagnosis consistent with the most recent version of Diagnostic and Statistical Manual (DSM) relevant to the need for ABA
    - Include a functional assessment using validated tools completed by the LBA, LABA or LMHP acting within the scope of practice.
    - include the reasons the youth needs ABA including how the youth meets medical necessity and eligibility criteria for the service
    - include information about the targeted behaviors including frequency, duration, and intensity
- The LBA, LABA or LMHP must, at a minimum, observe the youth monthly. Assessments must be reviewed and updated at least annually by the LBA, LABA or LMHP.
- Individual Service Plans (ISPs see Chapter IV of the DMAS manual for requirements) shall be required during the entire duration of services and must be current. ISPs must be reviewed at a minimum of every 30 calendar days or more frequently depending on the youth's needs. Refer to Chapter IV for additional guidance and documentation requirements for the 30 day review as well as additional quarterly review requirements. In addition to the requirements in Chapter IV of the DMAS manual, ISPs must include:
    - Youth Focused ABA Treatment Goals and Objectives
        - All preliminary goals and objectives presented in a way that summarizes and defines the overall approach to the youth's treatment based on the clinical needs and target behaviors as defined in the assessment summary
        - Prioritization of the treatment focus defined according to the severity of need
        - Description of how the provider will measure progress
        - Baseline status (as identified during the assessment and parent interviews) describing the intensity, frequency and duration of each behavior that is targeted for therapy
    - Parent and Caregiver Goals and Objectives
        - Describe the goals for parent/caregiver education related to the youth's behaviors to be achieved within the authorized time period
        - Describe the specific objectives and the methods used to measure progress within each goal area
        - Describe the goals for other care provider's education related to the youth's behaviors. Other care providers may include Medicaid Home and Community Based Waiver funded attendants and relatives who routinely come in contact with the youth.
    - Care Coordination Goals
        - Specific description of the care coordination and/or referral activities that will be implemented by the provider within the authorized time period to facilitate ISP outcomes based on the assessed needs of the youth and family including the families desired outcomes from receiving services
        - Specific care coordination treatment goals and the desired outcome based on the services provided by the ancillary service provider
        - Referrals to medical services (such as Speech-Language Pathology services, Occupational Therapy, Physical Therapy, Neurological services and Psychiatric services) and case management services to facilitate access to desired medical services including the desired outcome from the collaborative efforts with each therapeutic discipline including the target dates for achievement
        - All goals and objectives presented in a way that summarizes and defines the overall approach including the prioritization of the treatment goals based on the clinical needs and target behaviors as defined in the assessment summary.
- Providers must communicate the results of the assessment and treatment planning to the youth's primary care provider. Care coordination with the youth's primary care provider is an essential component of the provision of ABA services and must be documented in the youth's record
- Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV of the DMAS manual).
- Family training related to the implementation of ABA must be included. Family training involving the youth's family and significant others shall

    - be for the direct benefit of the youth and not for the treatment needs of the youth's family or significant others
    - occur with the youth present except when it is clinically appropriate for the youth to be absent in order to advance the youth's treatment goals
    - be aligned with the goals of the youth's ISP.
- Direct family involvement in the treatment program is required at a minimum of weekly but the amount of direct interaction with the treatment provider will vary according to the clinical necessity, progress as documented, and the youth and family goals in the ISP. Family involvement includes, but is not limited to, assessment, family training, family observation during treatment, updating family members on the youth's progress and involving the family in updating treatment goals.
- Clinical supervision shall be required for services rendered by a LABA, LMHP-R, LMHP-RP, or LMHP-S. Clinical supervision must be consistent with the scope of practice as described by the applicable Virginia Department of Health Professions (DHP) regulatory board.
- Supervision of unlicensed staff shall occur at least twice a month by the licensed supervisor. As documented in the youth's medical record, supervision shall include a review of progress notes and data and dialogue with supervised staff about the youth's progress and effectiveness of the ISP. Supervision shall be demonstrated by, at a minimum, the contemporaneously dated signature of the supervision activities by the licensed supervisor.

Family training related to the implementation of ABA shall be included. ABA may be provided in the home or community settings where the targeted behaviors are likely to occur. ABA may also be provided in clinic settings. Limited services are allowed in the school setting (see service limitations section). The setting must be justified in the ISP.

Refer to the Billing Guidance section for a list of approved Current Procedural Terminology (CPT) codes.

## Criteria:

Applied Behavioral Analysis is considered medically necessary for **all of the following**:

- Treatment is for **1 or more of the following**:
    - **Initial Care** with **all of the following**:
        - The youth must have a current psychiatric diagnosis as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) or have a provisional psychiatric diagnosis as developed by an LMHP when no definitive diagnosis has been made
        - The youth must meet criteria on a continuing or intermittent basis at least **2 or more** of the following:
            - Non-verbal or limited functional communication and pragmatic language, unintelligible or echolalic speech, impairment in receptive and/or expressive language
            - Severe impairment in social interaction /social reasoning /social reciprocity/ and interpersonal relatedness
            - Frequent intense behavioral outbursts that are self-injurious or aggressive towards others
            - Disruptive obsessive, repetitive, or ritualized behaviors
            - Difficulty with sensory integration
        - There is a family/caregiver available to participate in this intensive service.
    - **Continuation of services** are considered medically necessary with **all of the** following:
        - Within the past thirty (30) calendar days, the youth has continued to meet the admission criteria for ABA as evidenced by at least **1 or more** of the following:
            - The youth's symptoms/behaviors and functional impairment persist at a level of severity adequate to meet admission criteria;
            - The youth has manifested new symptoms that meet admission criteria and those have been documented in the ISP;
            - Progress toward identified ISP goal(s) is evident and has been documented based upon the objectives defined for each goal, but not all of the treatment goal(s) have been achieved.
        - To consider approval for continued stay requests, documentation will be reviewed and should demonstrate active treatment and care coordination through **all of the** following:

- An individualized ISP with evaluation and treatment objectives appropriate for this level of care and type of intervention
- Progress toward objectives is being monitored as evidenced in the 30 calendar day ISP review documentation
- The youth and family/caregiver are actively involved in treatment, or the provider has documented active, persistent efforts that are appropriate to improve engagement
- The type, frequency and intensity of interventions are consistent with the ISP
- The provider has developed an individualized discharge plan that includes specific plans for appropriate follow-up care

- If youth **does not meet criteria for continued treatment**, ABA may still be authorized for up to an additional 10 calendar days under any **1 or more** of the following circumstances:
  - There is no less intensive level of care in which the objectives can be safely accomplished
  - The youth can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the youth to be discharged directly to a less intensive community service rather than to a more restrictive setting
  - The youth is scheduled for discharge, but the youth requires services at discharge which are still being coordinated and are not currently available.
  - Service authorizations shall meet the components related to Procedures Regarding Service Authorization of Mental Health Services.

In addition to the “Non-Reimbursable Activities for all Mental Health Services” section in Chapter IV of the DMAS manual, the following service limitations apply:

- Group treatment should include no more than five youth. Multiple family group treatment should include no more than five caregivers. Groups may exceed this size based on the clinical determination of the LBA, LABA or LMHP. The LBA, LABA or LMHP must document the clinical justification for larger group sizes.
- ABA CPT codes are limited to 97151, 97152, 97156 and 97157 in Residential Treatment Services settings including Therapeutic Group Homes (TGHs) and Psychiatric Residential Treatment Facilities (PRTFs).
- Services cannot be authorized concurrently with
  - Intensive In-Home,
  - Mental Health Skill Building,
  - Psychosocial Rehabilitation,
  - Partial Hospitalization Program,
  - Assertive Community Treatment.
  - 14-calendar day service authorization overlap with these services is allowed as youth are being admitted or discharged from ABA to other behavioral health services (see service authorization section).
- The following shall not be covered under ABA:
  - Services that are based upon an incomplete, missing, or outdated assessment or ISP.
  - Sessions that are conducted for recreation respite or childcare.
  - Services rendered primarily by a relative or guardian who is legally responsible for the youth's care.
  - Services that are provided in the absence of the youth or a parent or other authorized caregiver identified in the ISP.
  - Services provided by a local education agency. ABA may only be provided in the school setting when the purpose is for observation and collaboration related to behavior and skill acquisition (not direct therapy) and services have been authorized by the school, parent and provider and included in the ISP.

**Exclusions:**

Services cannot be authorized concurrently with Intensive In-Home, Mental Health Skill Building, Psychosocial Rehabilitation, Partial Hospitalization Program or Assertive Community Treatment. 14-calendar day service authorization overlap with these services is allowed as youth are being admitted or discharged from ABA to other behavioral health services.

## Discharge Criteria:

The provider must terminate ABA if the service is no longer medically necessary. The service is no longer deemed medically necessary if **1 or more** of the following criteria is met within a thirty day time period:

- No meaningful or measurable improvement has been documented in the youth's behavior(s) despite receiving services according to the ISP; there is reasonable expectation that the family and /or caregiver are adequately trained and able to manage the youth's behavior; and termination of the current level of services would not result in further deterioration or the recurrence of the signs and symptoms that necessitated treatment.
- Treatment is making the symptoms persistently worse or the youth is not medically stable for ABA to be effective
- The youth has achieved adequate stabilization of the challenging behavior and less intensive modes of therapy are appropriate
- The youth demonstrates an inability to maintain long-term gains from the proposed ISP
- The family and/or caregiver refuses or is unable to participate meaningfully in the behavior treatment plan.

  If there is a lapse in service for more than 30 consecutive calendar days, the provider must discharge the youth from services and notify the FFS Contractor or MCO. If services resume after a break of more than 30 consecutive calendar days, a new service authorization request including a new assessment and ISP must be submitted to the FFS Contractor or MCO.

## Coding:

Medically necessary with criteria:

| Coding | Description |
|---|---|
| 97151 | Behavior identification assessment, administered by a physician or other qualified health care professional,<br>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<br>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<br>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<br>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<br>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 |

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| | 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 |
| 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. |
| H2014 | Skills training and development, per 15 minutes |

Considered Not Medically Necessary:

| Coding | Description |
|---|---|
| | None |

U.S. Food and Drug Administration (FDA) - approved only products only.

## Document History:

Revised Dates:

- 2023: July
- 2022: June

Reviewed Dates:

- 2022: September

Effective Date:

- December 2021

## References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

Behavioral health professionals are involved in the decision-making process for behavioral healthcare services.

(2022). Retrieved Aug 1, 2022, from CMS.gov: https://www.cms.gov/medicare-coverage-database/search-results.aspx?keyword=Applied+Behavioral+Analysis&keywordType=starts&areaId=all&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all

Applied Behavioral Analysis (B-806-T). (2022). Retrieved Aug 1, 2022, from MCG 25th Edition: https://careweb.careguidelines.com/ed25/index.html

Autism spectrum disorder in children and adolescents: Behavioral and educational interventions. (2020, Jan 1). Retrieved Aug 1, 2022, from UpToDate: https://www.uptodate.com/contents/autism-spectrum-disorder-in-children-and-adolescents-behavioral-and-educational-interventions?search=Applied%20Behavioral%20Analysis&source=search_result&selectedTitle=1~17&usage_type=default&display_rank=1

Behavioral Health: Applied behavior analysis. (2022). Retrieved Jul 29, 2022, from DMAS: https://www.dmas.virginia.gov/for-providers/rates-and-rate-setting/procedure-fee-files-cpt-codes/

Direct-To-Patient Applied Behavior Analysis Telehealth For Children with Autism Spectrum Disorder - Jan 31, 2022. (n.d.). Retrieved Aug 1, 2022, from Hayes: https://evidence.hayesinc.com/report/earb.directaba5285

Identification, Evaluation, and Management of Children With Autism Spectrum Disorder. (2020). Retrieved Aug 1, 2022, from THE AMERICAN ACADEMY OF PEDIATRICS: https://publications.aap.org/pediatrics/article/145/1/e20193447/36917/Identification-Evaluation-and-Management-of?autologincheck=redirected

Practice Parameter for the Assessment and Treatment of Children and Adolescents With Autism Spectrum Disorder. (2014). Retrieved Aug 1, 2022, from THE AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY (AACAP): https://www.jaacap.org/article/S0890-8567(13)00819-8/pdf

## Special Notes: *

This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

Keywords:

Applied Behavioral Analysis, ABA, Behavioral Health 37, BH, Autism, Intensive Community Based Support, youth, spectrum disorder, Mental Health Services, Autistic Children