

Clinical Policy: Applied Behavior Analysis

Reference Number: CP.BH.104

Last Review Date: 01/24

[Coding Implications](#)
[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Applied Behavior Analysis (ABA) is the application of behavioral principles to everyday situations, intended to increase skills or decrease targeted behaviors. ABA has been used to improve areas such as language, self-help, and play skills, as well as decrease behaviors such as aggression, self-stimulatory behaviors, and self-injury. For those with autism spectrum disorder (ASD), treatment may vary in terms of intensity and duration, complexity, and treatment goals. The extent of treatment provided can be characterized as focused or comprehensive. Focused ABA is direct care provided for a limited number of behavioral targets. Comprehensive ABA is for treatment of multiple affected developmental domains, such as cognitive, communicative, social, emotional, and adaptive functioning.¹

Centene will collaborate with providers to implement best practices and standardization of outcome measures into the Applied Behavior Analysis treatment plan.

Policy/Criteria

1. It is the policy of Centene Advanced Behavioral Health and health plans affiliated with Centene Corporation® that when a covered benefit, *Applied Behavior Analysis (ABA) services* are **medically necessary** when meeting all the following (general criteria in section A through D and service-specific criteria in section E):
 - A. A comprehensive diagnostic evaluation has been conducted within the past five years and includes a thorough summary demonstrating the effects of current symptoms on the member/enrollee's functional level in various settings (e.g., family, peer, school), specifically in the areas of communication, socialization, restricted/repetitive patterns of behavior, and adaptive functioning;
 - B. The member/enrollee has a confirmed autism spectrum disorder (ASD) diagnosis according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5TR) criteria or an appropriate diagnosis as otherwise specified according to state-defined ABA criteria;
 - C. The ASD diagnosis, including severity level, is confirmed by one of the following screening tools:
 1. Checklist for Autism in Toddlers (CHAT);
 2. Modified Checklist for Autism in Toddlers/Modified Checklist for Autism in Toddlers, Revised with follow-up (M-CHAT/M-CHAT-R/F);
 3. Screening Tool for Autism in Toddlers & Young Children (STAT);
 4. Social Communication Questionnaire (SCQ);
 5. Autism Spectrum Screening Questionnaire (ASSQ);
 6. Childhood Autism Spectrum Test, formerly known as the Childhood Asperger's Syndrome Test (CAST);
 7. Krug Asperger's Disorder Index (KADI);

8. Autism Diagnostic Observation Schedule/Autism Diagnostic Observation Schedule 2nd edition (ADOS/ADOS-2);
9. Autism Diagnostic Interview Revised (ADI-R);
10. Childhood Autism Rating Scale/ Childhood Autism Rating Scale 2nd edition (CARS/CARS-2);
11. Gilliam Autism Rating Scale (GARS-3);
12. Other valid form of approved evidence-based assessment result/summary;
- D. ABA is recommended by a physician, psychologist, social worker, or another appropriately licensed health care practitioner working within their scope of practice and who is qualified to diagnose ASD and recommend ABA;
- E. Requested service meets one of the following:
 1. *Behavioral assessment*, completed prior to requesting treatment services, includes both of the following:
 - a. Documentation includes all the following:
 - i. Past records;
 - ii. Interviews;
 - iii. Rating scales;
 - iv. Direct observation;
 - b. One or both of the following types of assessment is required, depending on the member/enrollee's noted areas of deficit:
 - i. For a member/enrollee that exhibits problem behaviors that are disruptive and/or dangerous, one of the following:
 - a) Functional behavioral assessment (FBA);
 - b) Traditional functional analyses;
 - c) Interview-Informed, Synthesized Contingency Analysis (IISCA);
 - ii. Skill acquisition assessment, one of the following:
 - a) Verbal Behavior Milestones and Assessment Placement Program (VB-MAPP);
 - b) Assessment of Basic Language and Learning Skills-Revised (ABLBSR);
 - c) Assessment of Functional Living Skills (AFLS);
 - d) Promoting the Emergence of Advanced Knowledge Generalization (PEAK) Skills Assessment;
 - e) Social Skills Improvement System (SSIS);
 2. *Initiation of ABA treatment*, all the following:
 - a. An ABA assessment was completed and contains all elements described in section [LE](#);
 - b. The treatment plan aligns with the results of the behavioral assessment and includes all of the following:
 - i. Individualized goals with measurable targeted outcomes and timelines, (including transition/discharge planning), that are communicated with providers, the member/enrollee and family members, incorporating the following characteristics:
 - a) Strengths-specific;
 - b) Family-focused;
 - c) Community-based;
 - d) Multi-system;

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- e) Culturally competent;
- f) Least intrusive;
- ii. The number of service hours requested meets all the following:
 - a) Is justified by the level of impairment calculated by the behavioral assessment, severity of symptoms, length of treatment history, and response to intervention;
 - b) Incorporates supervision and care giver training;
 - c) Considers the member/enrollee's age, school attendance requirements, and other daily activities;
 - d) Outlines hours of therapy per day with the goal of increasing or decreasing the intensity of therapy as the member/enrollee's ability to tolerate and participate permits. Note: Focused ABA treatment plan generally ranges from 10 to 25 hours per week or comprehensive ABA treatment plan generally ranges from 30 to 40 hours per week;
- iii. Parent or caregiver training that is performance based and caregiver-driven;
- iv. Documentation that ABA treatment will be delivered or supervised by an ABA credentialed professional and is consistent with ABA techniques (Note: Two hours of supervision per 10 hours of direct treatment is considered standard of care in most cases; two hours of supervision is required if direct treatment totals less than 10 hours per week);
- v. Documented coordination of care and communication regarding provider responsibilities with auxiliary providers (i.e., school, prescribers, and physical, occupational and/or speech therapists, etc.), the member/enrollee and family members;
- vi. Interventions focused on active core symptoms and emphasizing generalization and maintenance of skills in areas of need noted in the assessments, including interventions related to development of spontaneous social communication, adaptive skills, and appropriate behaviors;
- c. The member/enrollee exhibits behavior that presents as clinically significant to self or others, such as the following:
 - i. Self-injury;
 - ii. Aggression toward others;
 - iii. Destruction of property;
 - iv. Elopement;
 - v. Severe disruptive behavior;
 - vi. Significant interference with daily living;
- d. The member/enrollee is medically stable and does not require 24 hour medical/nursing monitoring or procedures provided in a hospital level of care;
- e. ABA treatment is not requested for services that are otherwise covered under the Individuals with Disabilities Education Act (IDEA). Unless restricted within a state Medicaid benefit, ABA services can occur in coordination with school services and transition plans;
- f. ABA treatment is not requested to meet treatment goals more appropriately conducted in any of the following disciplines:
 - i. Behavioral health outpatient services;
 - ii. Speech therapy;

- iii. Occupational therapy;
 - iv. Vocational rehabilitation;
 - v. Supportive respite care;
 - vi. Recreational therapy;
 - vii. Orientation and mobility;
3. *Continuation* of ABA treatment, all the following:
- a. Criteria for *initiation* of services continues to be met. Note: A comprehensive diagnostic evaluation (CDE) must be completed every five years to reevaluate the ASD diagnosis;
 - b. Assessments are performed consistent with criteria in [I.E.1.b.](#) and assessments, evaluations, treatment plans, and documentation are current within each profession, licensure, and state standards and completed at a minimum of every six months during ABA treatment;
 - c. Discharge criteria has been reviewed and adjusted according to progress and indicates the point at which services are appropriate for discontinuation and/or transfer to alternative or less intensive levels of care;
 - d. ABA treatment is not making symptoms worse;
 - e. There is a reasonable expectation that the member/enrollee will benefit from the continuation of ABA services due to one of the following:
 - i. Documented progress toward goals within six months from the last authorization (or less, as clinically appropriate, or as state mandated), as evident by mastery of skills defined in the initial treatment plan commensurate with level of care provided, and both of the following:
 - a) New goals have been formulated based on targeted symptoms and behaviors;
 - b) A transition plan toward titration of services;
 - ii. Documentation supports that limited progress has been made toward goals within six months of the last authorization (or less as clinically appropriate), both of the following:
 - a) An updated assessment identifies determining factors that may be contributing to inadequate progress;
 - b) Changes from the treatment plan in the prior authorization period include all of the following:
 - 1) Reevaluation of each treatment plan goal;
 - 2) Increased time and/or frequency working on targets;
 - 3) Increased parent/caregiver training and supervision;
 - 4) Identification and resolution of barriers to treatment effectiveness;
 - 5) Any newly identified co-existing conditions;
 - 6) Consideration of alternative treatment settings;
 - 7) Consideration of the effectiveness of ABA. Note: An updated, comprehensive diagnostic evaluation may be warranted to identify if psychological factors other than the autism spectrum disorder are impeding progress;
 - 8) Evaluation for other services that may be helpful for added support:

- i) Speech therapy;
 - ii) Occupational therapy;
 - iii) Psychiatric evaluation;
 - iv) Psychotherapy;
 - v) Case management;
 - vi) Family therapy;
 - vii) Feeding therapy;
 - viii) School based supports;
 - f. Treatment plan includes the following:
 - i. Interventions consistent with ABA techniques that align with the updated assessment;
 - ii. Requested treatment hours meet all the following:
 - a) Based on response to treatment and current needs;
 - b) Necessary to effectively address the member's skill deficits and behavior reduction goals;
 - c) Consider the member's age, school attendance requirements, and other daily activities when determining the number of hours for direct service, group, and supervision hours;
 - iii. Qualitative and quantitative data are provided and meet all the following:
 - a) Gathered from ABA providers as well as from parents/guardians, teachers, and other caregivers (such as speech therapists, occupational therapists);
 - b) Collected from multiple settings as applicable, such as in clinic, home, and school;
 - c) Includes a description of the change over time on all behaviors and skills that are the focus of treatment;
 - d) Clearly documented and easily interpretable;
- II.** It is the policy of Centene Advanced Behavioral Health and affiliated health plans with Centene Corporation that when a covered benefit, *Applied Behavior Analysis (ABA) services* may be appropriate for discontinuation and/or transfer to alternative or less intensive levels of care when meeting all the following:
 - A. Transition planning and discharge considerations are made with input from the entire care team and generally involve a gradual step-down in services;
 - B. Discharge criteria is clearly defined and measurable;
 - C. Any of the following are met:
 - 1. Member/ Enrollee no longer meets continued stay criteria and/or meets criteria for another level of care;
 - 2. The individual treatment plan goals have been met;
 - 3. The parent/guardian/caregiver can continue the behavioral interventions independently;
 - 4. The parent/guardian withdraws consent for treatment;
 - 5. There is expected transition to the utilization of community resources for alternative treatment, specifically that of a school setting;
 - 6. Documentation that there has been no clinically significant progress or measurable improvement towards treatment plan goals for a period of at least six months, and

there is not a reasonable expectation that a revised treatment plan could lead to clinically significant progress.

Background

Applied Behavioral Analysis (ABA) is based on the premise that behavior is determined by past and current environmental events in conjunction with organic variables such as genetic attributes and physiological variables. It focuses on changing the member/enrollee's social and learning environments to promote a change in behavior. Services may be provided in various settings (e.g., home, clinic, school, community) and modalities (e.g., in-person, telehealth) to increase adaptive skills and decrease challenging behaviors.¹

In 2008, Ospina and colleagues, systematically reviewed studies comparing behavioral and developmental interventions for ASD using quality assessment, sensitivity analyses, meta-regression, dose-response meta-analysis and meta-analysis of studies of different metrics. The results suggested that long term, comprehensive ABA intervention leads to positive (medium to large) effects in intellectual functioning, language development, acquisition of daily living skills and social functioning in children with autism.²

*Council of Autism Service providers (CASP)*¹

The Council of Autism Service Providers (CASP) has developed guidelines and recommendations that reflect established research findings and best clinical practices. These guidelines focus on the use of ABA as a behavioral health treatment to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual with ASD. ABA includes the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. Services will fall into two treatment models Focused ABA and Comprehensive ABA.

Focused ABA treatment is treatment provided directly to the member/enrollee for a limited number of behavioral targets. It is not restricted by age, cognitive level, or co-occurring conditions. Focused ABA treatment may involve increasing socially appropriate behavior (e.g., increasing social initiations) or reducing problem behavior (e.g., aggression) as the primary target. Focused ABA plans are appropriate for individuals who need treatment only for a limited number of key functional skills or have such acute problem behavior that its treatment should be the priority.

Comprehensive ABA refers to treatment of the multiple affected developmental domains, such as cognitive, communicative, social, emotional, and adaptive functioning. Maladaptive behaviors, such as noncompliance, tantrums, and stereotypy are also typically the focus of treatment. Although there are several types of comprehensive treatment, one example is early intensive behavioral intervention where the goal is to close the gap between the member/enrollee's level of functioning and that of typically developing peers. Intensity levels range from 30-40 hours of treatment per week (plus direct and indirect supervision and caregiver training), however, the intensity of comprehensive treatment must be individualized to the member/enrollee's characteristics and other factors. Initially, this treatment model typically involves 1:1 staffing and gradually includes small-group formats as appropriate.

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According to CASP the following are four core characteristics essential to the practice elements of ABA treatment:

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

Due to a shortage of providers and disparities which exist in behavioral health care access, telehealth services have become a viable solution to address health access to treat members/enrollees with ASD. This service is not intended to replace in person service, as it is intended to supplement the traditional in person service delivery model.⁴ Clinical decisions on telehealth service delivery models should be selected based on the individual needs, strengths, preference of service modality, caregiver availability and environmental support available. Providers should refer to respective state allowances for telehealth services and reference the most updated CASP Practice Parameters for Telehealth-Implementation of Applied Behavior Analysis.³

*American Academy of Pediatrics (AAP)*⁴

The APA recommends that all children be screened for ASD at ages 18 and 24 months, along with regular developmental surveillance. Toddlers and children should be referred for diagnostic evaluation when increased risk for developmental disorders (including ASD) is identified through screening and/or surveillance. Although symptoms of ASD are neurologically based, they manifest as behavioral characteristics that present differently depending on age, language level, and cognitive abilities. Core symptoms cluster in 2 domains (social communication, interaction and restricted, repetitive patterns of behavior), as described in the DSM-5TR.

*The Diagnostic and Statistical Manual of Mental Disorder, Fifth edition (DSM-5-TR)*⁵

The Diagnostic and Statistical Manual of Mental Disorder, list the following as the severity levels for autism spectrum disorders: They are divided into two domains (social communication and social interaction and restrictive, repetitive patterns of behaviors) To fulfill diagnostic criteria for ASD by using the DSM-5 TR, all 3 symptoms of social affective difference need to be present in addition to 2 of 4 symptoms related to restrictive and repetitive behaviors.

Severity Level	Social Communication	Restricted, repetitive behaviors
Level 3 “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. For example, a person with few words of intelligible speech who rarely initiates interaction and when he/she does, makes	Inflexibility of behavior, extreme difficulty coping with change or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changes focus or action.

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	unusual approaches to meet needs only and responds to only very direct social approaches.	
Level 2 “Requiring substantial support”	Marked deficits in verbal and nonverbal communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interest, and who has markedly odd nonverbal communication.	Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer in a variety of context. 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 who’s to and from conversation with others fails, and who attempts to make friends are odd and typically unsuccessful.	Inflexibility of behavior causes significant interference with functioning in one or more context. Difficulty switching between activities. Problems of organization and planning hamper independence.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2022, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®*	Description
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 one 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

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CPT®* Codes	Description
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
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

Reviews, Revisions, and Approvals	Date	Approval Date
Initial approval		08/09
Updated policy to “Applied Behavioral Analysis” and description. Split criteria into initial and continuation and removed authorization protocols. Combined diagnostic specific screening tools into one section and removed confirmation of diagnosis by specialist type in II.B. Add DSM-5 to list in II.D. Added length of failure for less intensive treatments. Changed treatment provided by requirements to a credentialed provider in continuation criteria, added reasonable expectations of therapy points.	12/14	01/15
Updated template. Updated background with recent studies. Changed policy reference number from CP.BH.02 to CP.MP.103. Specialist reviewed.	01/16	01/16
Reviewed and updated references. Added ICD-10 codes.	12/16	01/17
Added language to further define ABA therapy to the section- Description. Revised I. C.2 to state that lead poisoning rather than heavy metal poisoning has been ruled out per American Academy of Neurology recommendation.	01/18	01/18
Specified which DSM-IV and DSM-5 diagnoses apply and broke these into separate criteria points. Added pediatric psychiatrist, neurologist, or developmental pediatrician as clinicians that can validate the ASD diagnosis.	05/18	05/18

Reviews, Revisions, and Approvals	Date	Approval Date
<p>Updated description to include definition of focused and comprehensive ABA treatment. Moved providers qualified to make diagnosis of ASD to I.A. and added PCP to this group. Added updated versions of various screening/diagnostic tests noted in in I.B and #12, “A valid form of approved evidenced based assessment result/summary” per recommendation of specialist. Removed requirement that neurological disorder, lead poisonings and primary speech or hearing disorder has been ruled out as this is implied. Added I.C., description of categories that justify ABA treatment; Added I.D treatment plan criteria for focused and comprehensive ABA. Under continuation of services, section II, removed requirement that treatment plan be reviewed on a monthly basis, revised review from 12 to 6 months in D & E. Added additional criteria I.F-H. Removed statement that an appropriate diagnostician has ruled out intellectual disability or global developmental delay as a sole explanation for symptoms of ASD as this implied in I.A. References reviewed and updated. Specialist reviewed.</p>	01/19	02/19
<p>Removed examples of physician types under I.A and added “qualified licensed professional.” Removed four-year-old requirement from I.A.4. Removed section specifying which individual therapies ABA is not for the sole purpose of providing in I.H.</p>	03/19	
<p>Changed policy number to CP.BH.104. Replaced “Applied Behavioral Analysis” with “Applied Behavior Analysis.” Replaced “Lovaas therapy” with Early Intensive Behavior Intervention (EIBI). Updated Section I. A. to include “ABA recommended by a qualified licensed professional” and added definition of “qualified licensed professional.” Removed DSM-5 Criteria from Section I.B, as this was duplicative. Replaced “plan of care” with “treatment plan” in Section I.D. and added “the number of service hours necessary to effectively address the skill deficits and behavioral excesses is listed in the treatment plan and considers the member/ enrollee’s age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service, group and supervision hours” to Section I. E. Replaced “challenging behaviors” with “skill deficits and behavioral excesses” in Section II.E. Added “and align with the identified areas of need in the assessments” to Sections I.I. and II. C. Added “Assessments, evaluations, treatment plans, and documentation is expected to be current within each profession, licensure, and state. standards.” to Section II. J.</p>	6/20	6/20
<p>Annual review. Reference list reviewed and updated. Changed “Review Date” in the header to “date of last revision” and “date” in the revision log header to “Revision date.”</p>	5/21	5/21
<p>Addition of treatment range for focused ABA and literature review in introduction. Addition of Medical necessity criteria for behavioral assessment. Addition of Intensity of Services for ABA. Addition of “or appropriate diagnosis as otherwise specified according to state defined ABA criteria” and removal of “clinical professional counselor, marriage and</p>	11/21	11/21

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<p>family therapist, addiction counselor”, addition of “strengths-specific, family-focused, community-based, multi-system, culturally competent, and least intrusive. And where specific target behaviors are clearly defined; frequency, rate, symptom intensity or duration” in criteria. Section III.D. updated definition. Addition of H, K, L, M in initiation of services criteria. Addition of K, L, M, N in continuation of ABA services criteria. Addition of transition planning section. Updated introduction and research studies including citations to section entitled “Background.” Addition of section Screening Recommendations for ASD. Changed “Last Review Date” in the policy header to “Date of Last Revision,” and “Date” in the revision log header to “Revision Date.”</p>		
<p>Edit of verbiage for caregiver training goals changed “Caregiver Training is performance based. Identifies measurable outcomes for every goal and objective including parent training” to “Caregiver training is performance based and parent driven. Identifies measurable outcomes for every goal and objective;” and formatted for to standard Clinical Policy format.</p>	1/12/22	1/22
<p>Added revision log entry form 5/21 which was previously omitted in error.</p>	06/22	6/22
<p>Annual Review. Policy restructured and reformatted. Reordered and reorganized criteria for clarity. Minor wording changes made for clarity. Removed redundant language. Removed all instances of dashes and replaced with the word “to.” Updated the description section to incorporate changes to the level of intensity hours for Comprehensive ABA from “25-40 hours” hour to “30-40 hours”. Replaced all instances of the statement: “It is the policy of Centene Advanced Behavioral Health and affiliated health plans” with “It is the policy of Centene Advanced Behavioral Health and health plans affiliated with Centene Corporation.” Replaced all instances of “member” to “member/enrollee.” Changed all instances of “dashes (-) in page numbers to the word “to.” Grammatical changes made to the background with no impact to the policy. References added, reviewed, updated, and reformatted.</p>	11/22	12/22
<p>Annual review. Replaced all instances of “DSM-5” with “DSM-5 TR”. Added requirement for a comprehensive diagnostic evaluation to have been conducted within the past five years in I.A.1. Added Social Skills Improvement System (SSIS) as an additional skill assessment option in I.E.1.b.ii.e. In I.E.,2.b. deleted “comprehensive.” Deleted I.E.,2.b.ii.e) and replaced it as a “note” under I.2.b.ii.d). In I.E.2.c.vi. deleted “in the home or community activities.” Added I.E.2.f.i. “Behavioral health outpatient services” to the list. Added statement to I.E.3.b. “Assessments are performed consistent with criteria in I.E.1. b.” Rearranged criteria point in I.E.3 for clarity. In II.A. added statement “... and generally involve a gradual step-down in services.” In II.C. Removed the statements “Services may be appropriate for discontinuation and/or transfer to alternative or less intrusive levels of care.” Removed ICD 10 chart. Updated description and background with no clinical significance. References reviewed and updated.</p>	11/23	11/23

Reviews, Revisions, and Approvals	Date	Approval Date
In policy statement I., corrected the requirement to meet general criteria in A through C to meeting A through D.	01/24	

References

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This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

CLINICAL POLICY

Applied Behavior Analysis

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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