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<tr><td colspan="2">MEDICAL POLICY STATEMENT<br>Michigan Marketplace</td></tr>
<tr><td>Policy Name & Number</td><td>Date Effective</td></tr>
<tr><td>Applied Behavior Analysis for Autism Spectrum Disorder-MI MP-MM-1641</td><td>01/01/2025</td></tr>
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<tr><td colspan="2">MEDICAL</td></tr>
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Medical Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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## A. Subject
**Applied Behavior Analysis for Autism Spectrum Disorder**

## B. Background
The *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Text Revised* (DSM-5-TR) classifies Autism Spectrum Disorder (ASD) as a neurodevelopmental disorder varying widely in severity and symptoms, depending on the developmental level and chronological age of the individual. ASD is characterized by specific developmental deficits that affect socialization, communication, academic, and personal functioning. Individuals are typically diagnosed before entering grade school, and symptoms are noticed across multiple contexts, including social reciprocity, nonverbal communicative behaviors, and skills in developing, maintaining, and understanding relationships. Restricted, repetitive patterns of behavior, interests, or activities are also often present.

Currently, there is no cure for ASD, nor is there any single treatment for the disorder. The diagnosis may be managed through a combination of therapies, including behavioral, cognitive, pharmacological, and educational interventions with a goal of minimizing the severity of ASD symptoms, maximizing learning, facilitating social integration, and improving quality of life for the member and family/caregiver(s). Applied behavior analysis (ABA), one such therapy, may be provided in centers or at home and provides an evidence-based practice for the treatment of ASD.

ABA is based on the science of behavior, which was founded on the premise that understanding behavior functioning, how it is affected by the environment, and how learning to change behavior can improve the human condition. It is a flexible treatment in that it should always be adapted to the needs of each individual, teaches skills that are useful and generalizable, and involves individual, group and family training. Qualified and trained practitioners provide and/or oversee ABA programs and are accountable to state boards for registration, certification, or licensure requirements. 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.

CareSource follows state law and guidelines in the provision of ABA services, which are based on a diagnosis from the *Diagnostic and Statistical Manual of Mental Disorders, 5th ed., Text Revised* (DSM-5-TR). Severity levels are divided into two domains, social communication and restricted, repetitive behaviors, and are defined by the *DSM-5-TR* as follows:

| Severity Levels for Autism Spectrum Disorder | | |
|---|---|---|
| Severity Level | Social Communication | Restricted, Repetitive Behaviors |
| Level 3 – “Requiring very | Severe deficits in verbal & nonverbal social communication skills cause severe impairments in functioning, very | Inflexibility of behavior, extreme difficulty coping with change, or other restricted/ repetitive behaviors markedly |

| | | |
|---|---|---|
| substantial support” | limited initiation of social interactions, and minimal response to social overtures from others. | 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. | 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 – “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. | Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence. |

C. Definitions

- **Autism Spectrum Disorder (ASD)** – *DSM-5-TR* disorder with identified diagnostic criteria and associated severity levels characterized by persistent deficits in social communication and interaction across multiple contexts and the presence of restricted, repetitive patterns of behavior, interests, or activities causing significant impairment.
- **Applied Behavior Analysis (ABA)** – 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.
- **Caregiver/Family Training** – Training taught by a therapist to parent/caregiver(s) on the implementation of methods utilized in a clinical setting into other environments, such as the home or community, to maximize outcomes furthering generalization of skills and maximizing and reinforcing methods being taught.
- **Independent Practitioner** – All ABA services must be provided by a Behavior Analyst Certification Board (BACB)-certified behavior professional/paraprofessional:
    - Board Certified Assistant Behavior Analyst (BCaBA)
    - Board Certified Behavior Analyst (BCBA)
    - Board Certified Behavior Analyst - Doctoral (BCBA-D)
    - Registered Behavior Technician (RBT)
- **Medically Unlikely Edit (MUE)** – The maximum units of service for one Current Procedural Terminology (CPT) code that a provider can report for one member on one date of service.
- **SMART Goals** – Goals that are specific (S), measurable (M), attainable (A),

relevant (R), and time-bound (T).

- **Standardized Diagnostic Assessment Tools** – Evidence-based tools designed to assist with identification of symptoms and criteria for a diagnosis or disorder.
- **Supervision** – Directing, guiding, training, and assessing individuals who provide behavior-analytic services with responsibilities in accordance with the Board from which the practitioner received a license.
    - Services delivered by a BCaBA must be supervised by a BCBA, BCBA-D, or a licensed psychologist who tested in ABA and is certified by the American Board of Professional Psychology in Behavioral and Cognitive Psychology. A BCaBA must be enrolled in the Marketplace program and affiliated with the organization under which the provider is employed or contracted.

## D. Policy

I. General Guidelines

A. Medical necessity review is required for all ABA services initially with a baseline and then, again, every 6 months. Appropriate documentation, as indicated in this policy, must be submitted for review and align with state's definitions of medical necessity that include that treatment is not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results.

B. ABA therapy should begin early in life, ideally by the age of 2, typically lasting 3 to 4 years and is subject to the member's response to treatment.

C. Members under the age of 21 will be assessed. Treatment goals and intensity will be based on individual needs and progress in treatment with a focus on remediation of symptoms.

II. Initiation of ABA Services

A. Documentation: CareSource must receive documentation that confirms the following medical criteria:

1. definitive, primary diagnosis of ASD made by one of the following practitioners upon evaluation who is independent of the ABA provider and has a relationship with the member:
    a. child and adolescent psychiatrist
    b. psychologist
    c. child neurologist
    d. developmental pediatrician
2. standardized diagnostic assessment tools were used as part of a referral for ABA services (eg, Autism Diagnostic Observation Schedule [ADOS], Autism Diagnostic Interview Revised [ADI-R], Childhood Autism Rating Scale, 2nd edition [CARS-2])
3. description of clinical symptoms (eg, provider letter) present within the past year that require treatment if the diagnostic evaluation was completed more than 24 months from the date of the request

B. A licensed ABA practitioner will perform a behavioral assessment (BA) and develop a treatment plan before services are provided. BAs are generally not to

exceed 8 hours every 6 months unless additional justification is provided.

C. Initial Treatment Plan: An initial ABA treatment plan individualized to the caregiver/family needs, values, priorities and circumstances for member goals and parent/caregiver training will be developed by the member, family/caregiver, and provider and must include the following:
   1. biopsychosocial information, including, but not limited to the following:
      a. current family structure
      b. medication history, including dosage and prescribing physician
      c. medical history
      d. school placement and hours in school per week, including homeschool instruction and any applicable individualized education plans (IEP)
      e. history of ABA services, including service dates (duration), type of therapy received, results, and progress notes (When previous ABA therapy information is unknown, documentation must be provided regarding why the information is inaccessible and how or if this will affect treatment.)
      f. all behavioral health diagnoses and services, including any hospitalizations
      g. other services the member is receiving or has received (eg, speech therapy [ST], occupational therapy [OT], physical therapy [PT]), including evidence of coordination with other disciplines involved in the assessment
      h. caregiver proficiency and involvement in treatment
      i. any major life changes
   2. rationale for ABA services and how ABA addresses current areas of need, including the following:
      a. a history with symptom intensity and symptom duration, as well as how the symptoms affect the member's ability to function in various settings
      b. evidence of previous therapy (eg, outcomes from previous ABA treatment, ST, OT, PT) and how results influence proposed treatment
      c. type, duration, and frequency for services
   3. goals related to core deficits (eg, communication problems, relationship development, social and problem behaviors) and including the following:
      a. outcome driven, performance-based, and individualized focused on targeted symptoms, behaviors, and functional impairments
      b. based on the behavioral assessment and a standardized developmental and functional skills assessment/curriculum (eg, Verbal Behavior Milestones Assessment and Placement Program [VB-MAPP], Assessment of Basic Language and Learning Skills [ABLLS-R]).
      c. a description of treatment activities and documentation of active participation by caregiver/family in the implementation of the treatment program **OR** documentation detailing barriers to family/ caregiver participation and how those barriers are being actively addressed
      d. SMART goals that define how improvement will be noted, frequency of treatment (number of hours per week), and duration of treatment
   4. Behavioral Intervention Plan and/or a Plan of Care (POC)

5. requested number of ABA hours per week based on the member's specific needs, not on a general program structure, as evidenced by **all** the following:
   a. Treatment is provided at the lowest level of intensity appropriate to the member's clinical needs and goals with the number of hours requested reflecting the actual number of hours intended to be provided.
   b. A detailed description of problems, goals and interventions support the requested intensity of treatment.
6. a plan to modify the intensity and duration of treatment over time based on the member's progress, including an individualized discharge plan specific to treatment needs
7. coordination with other behavioral health and medical providers

D. Authorization for Initial Course of Treatment
1. Once the diagnostic evaluation is authorized and completed, the treatment plan (see above) must be submitted for approval.
2. In addition to the submitted treatment plan, the treating BCBA must include the following:
   a. any baseline measurements
   b. progress reports, particularly documentation of rationale for any adjustment of hours per week upon regular treatment review
3. Individualized parent/caregiver training, including documented plans for the training and parent/caregiver ability and willingness to learn and use therapy techniques in the home.
4. School transition plans that include the following:
   a. attendance at school, if age appropriate
   b. plans to transition to school, if not currently attending
   c. plans to be able to attend school without additional ABA therapy outside the school setting
5. Documentation that a licensed or certified behavior analyst will be providing ABA therapy services.

III. Continuation of ABA
Requests for continuation of ABA services are to be submitted every six months, and documentation must meet **EITHER** of the following criteria:
A. A definitive diagnosis of ASD persists, and member continues to demonstrate ASD symptoms that will benefit from treatment in at least 2 settings.
B. A treatment plan as noted in D. II. C., including the following:
   1. an updated progress report with assessment scores that note improvement and member response to treatment from baseline targeted symptoms, behaviors, and functional impairments using the same modes of measurement utilized for baseline measurements
   2. a plan to transition services in intensity over time
   3. utilization of prior approved hours
C. Parent/caregiver(s) are involved and making progress in development of behavioral interventions.

**OR**

D. When requesting continuation with inadequate progress on targeted symptoms or behaviors or no demonstrable progress within a 6-month period, an assessment of the reasons for lack of progress should be documented and provided. Treatment interventions should be modified to achieve adequate progress. Documentation should include
   1. change in possible treatment techniques
   2. increased parent/caregiver training
   3. increased time and/or frequency working on specific targets
   4. identification and resolution of barriers to treatment efficacy
   5. any newly identified co-existing disorders and possible treatment
   6. modified or removed goals and interventions

IV. Discontinuation of ABA Therapy
Titration and/or discontinuation of ABA therapy should occur when the following conditions are met (not an all-inclusive list):
A. Treatment ceases to produce significant meaningful progress or maximum benefit has been reached.
B. Member behavior does not demonstrate meaningful progress for two successive 6-month authorization periods as demonstrated via standardized assessments.
C. ABA therapy worsens symptoms, behaviors or impairments.
D. Symptoms stabilize allowing member to transition to less intensive treatment or level of care.
E. Parents/caregivers have refused treatment recommendations, are unable to participate in the treatment program, and/or do not follow through on treatment recommendations to an extent that compromises the effectiveness of the services for member progress.

V. Parent/Caregiver Training
Training will evolve as goals are met. ABA services must include documentation of the following:
A. Parent/caregiver(s) understand and agree to comply with the requirements of treatment.
B. The treatment request addresses how the parent/caregiver(s) will be trained in skills that can be generalized to the home and other environments.
C. The treatment plan includes methods by which the parent/caregiver(s) will demonstrate trained skills.
D. Barriers to parent involvement and plans to address are noted (eg, does parent/caregiver address treatment goals when treatment professionals are not present, parent/caregiver overall skill abilities).
E. Parent/caregiver time involvement, including any materials or meetings occurring on a routine basis, is documented.
F. Parent/caregiver should be actively working on at least one unmet goal.

VI. Telehealth

Parent/caregiver training and supervision may be provided by telehealth. 1:1 ABA services may be provided via telehealth in instances deemed medically necessary with supporting documentation that provides a plan for the provision of service delivery.

VII. Other Documentation Requirements

States enact code and guidelines related to requirements for documentation expectations for client records maintained for third party billing. All written, electronic, and other records will be stored and disposed of in such a manner as to ensure confidentiality. All must be legible. General documentation requirements are included in CareSource's policies *Behavioral Health Service Record Documentation Standards* and *Medical Record Documentation Standards for Practitioners*.

A. Minimum documentation requirements for ABA client records include the following:
   1. presenting problem, including any relevant diagnosis and any recommendation for ABA services rendered by a licensed professional
   2. date(s) and purpose of each service contact
   3. fee arrangement or practices in compliance with applicable laws and regulations
   4. treatment plan and functional assessment on which the behavior plan is based
   5. data collected to ascertain efficacy of ABA and any subsequent modifications of the plan
   6. notation and results of formal contacts with other providers
   7. authorizations, if any, by the client for release of records or information
B. Additional information to be included on any service note includes
   1. start and stop times of the session
   2. place of service
   3. provider rendering the service with appropriate credentials
   4. participants attending the session
   5. interventions occurring during the session that directly related to the POC
   6. client response to interventions
   7. any needed modifications to treatment or items requiring followup from previous sessions

VIII. Codes of Conduct

Codes of conduct exist to meet credentialing needs of professionals but also function to protect members by establishing, disseminating, and managing professional standards. States mandate that providers of ABA services understand and follow codes of conduct supporting the profession. CareSource supports professional standards established by licensing and credentialing bodies, and therefore, encourages professional compliance to any and all standards across disciplines for the protection of members and families. The ethics code written by the Behavior Analyst Certification Board includes the following standards (not all-inclusive):

A. Family oversight must occur by/with the BCBA or BCaBA. An RBT may be present during a family training session to provide assistance with interventions, but the training or supervision of interventions cannot be completed by the RBT.
B. Providers will create a contract for consent to services (eg, "Declaration of Professional Practices and Procedures") at the onset of services that defines and documents, in writing, the professional role with relevant parties.
C. Appropriate effort will be made to involve members and stakeholders in treatment, including selecting goals, designing assessments and interventions, and conducting continual progress monitoring.
D. Providers will identify and address environmental conditions (eg, behavior of others, hazards to client or staff) that may interfere with service delivery, including the identification of effective modifications to interventions and appropriate documentation of conditions, actions taken, and eventual outcomes.
E. Continuity of services will be facilitated to avoid interruption or disruption of services for members, including documentation of actions taken and eventual outcomes.
F. Providers will address any possible circumstances when relevant stakeholders are not complying with the behavior-change intervention(s) despite documented and appropriate efforts to address barriers to treatment.

IX. Supervision Expectations

States require that appropriate supervision of services occur for any provider of services not acting independently. The BACB provides guidelines for supervision requirements and documentation expectations for providers within the profession.

A. Record Maintenance
   Supervision records will be maintained for 7 years, following the termination of supervision, which include the following documents, at a minimum:
   1. supervision plans for each client treatment plan
   2. dates of training on treatment plans, procedures, and interventions
   3. supervision provided when treatment plans are reviewed or modified
B. RBTs must document the following during supervision (not all-inclusive):
   1. days and times behavior-analytic services were provided
   2. dates and duration of supervision
   3. supervision format (individual, group)
   4. dates of direct observation
   5. names of supervisors providing supervision
   6. noncertified RBT supervisor form, if applicable
   7. proof of supervisor's relationship to the client
   8. additional documentation in the event of discrepant records (session notes)
C. Supervisors must document the following for any supervision hours conducted (not an all-inclusive list):
   1. date with start and stop times
   2. fieldwork type
   3. supervision type (group, individual)
   4. activity category (restricted or unrestricted)

5. summary of supervision activity, including
    a. discussion of activities completed during independent hours and any feedback provided
    b. progress toward individual member goals
    c. outcome of supervision, including any modification to treatment interventions or plans of care
    d. collaboration of care among providers
6. dated signatures of supervisor and supervisee, including credentials

D. Observations must include the following (at a minimum):
1. date with start and stop times
2. fieldwork type
3. setting name
4. supervisor name
5. activity category (restricted or unrestricted)

X. Special Provisions Related to RBTs
A. Current Standards for RBTs
1. RBT services must be supervised by a qualified RBT supervisor. RBTs must obtain ongoing supervision for a minimum of 5% of the hours spent providing ABA services per month. Services delivered by an RBT must be supervised by a BCBA, BCBA-D, or a licensed psychologist who tested in ABA and is certified by the American Board of Professional Psychology in Behavioral and Cognitive Psychology.
2. An RBT certified by the National Behavior Analyst Certification Board may provide ABA under the supervision of an independent practitioner affiliated with the organization under which the provider is employed or contracted. If the independent practitioner leaves the affiliated organization and no longer provides supervision, the RBT may not continue to provide services under that independent practitioner. Additionally, if the RBT leaves the affiliated organization and no longer receives mandated supervision, the RBT may not continue to provide services to the member.
3. RBTs must use appropriate modifiers that indicate qualifications of staff delivering services.

B. Upcoming RBT Changes from the Behavior Analyst Certification Board
1. **Effective January 1, 2026:** In the interest of consumer protection, the BACB Board of Directors approved a recommendation that RBT supervisors must hold BCBA or BCaBA certification. Noncertified supervisors will not be allowed to provide BACB-required supervision to RBTs. During this transition, RBT Requirements Coordinators who currently attest to the qualifications of noncertified supervisors should make preparations to ensure continuity of care for clients.
2. **Effective January 1, 2026:** New rules regarding eligibility for and maintenance of certification for RBTs were adopted by the BACB Board of Directors and can be located in the *BACB Newsletter: December 2023* at www.bacb.com.

XI. Exclusions
   A. reimbursement for the following services or activities is not permitted:
      1. any services not documented in the treatment plan
      2. behavioral methods or modes considered experimental
      3. education-related services or activities described under Individuals with Disabilities Education Improvement Act of 2004, 20 U.S.C. §1400 (IDEA)
      4. vocational services in nature or those available through programs funded under Section 110 of the Rehabilitation Act of 1973
      5. components of adult day care programs
   B. treatment solely for the benefit of the family, caregiver, or therapist
   C. treatment focused on recreational or educational outcomes
   D. treatment worsening symptoms or prompting member regression
   E. treatment for symptoms and behaviors not part of core symptoms of ASD (eg, impulsivity due to ADHD, reading difficulties due to learning disabilities, excessive worry due to an anxiety disorder)
   F. goals focused on academic targets (eg, treatment should address autistic symptoms impeding deficits in the home environment, such as reduction of frequency of self-stimulatory behavior to follow through with toilet training or completing a mathematic sorting task)
   G. treatment unexpected to cause measurable, functional improvement or improvement is not documented
   H. duplicative therapy services addressing the same behavioral goals using the same techniques as the treatment plan, including services under an IEP
   I. more than 1 program manager or lead behavioral therapist or more than 1 agency or organization providing ABA for a member at any 1 time
   K. services provided by family or household members
   L. care primarily custodial in nature and not requiring trained/professional ABA staff
   M. shadowing, para-professional, or companion services in any setting
   N. personal training or life coaching
   O. services are more costly than alternative service(s), which are as likely to produce equivalent diagnostic or therapeutic results for the member
   P. any program or service performed in nonconventional settings, even if performed by a licensed provider (eg, spas/resorts, vocational or recreational settings, Outward Bound, wilderness, camp or ranch programs)

E. Conditions of Coverage
   I. Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis, subsequent medical review audits, recovery of overpayments identified, and provider prepayment review.

   II. CareSource reserves the right to request supervision documentation.

   III. CareSource complies with the Centers for Medicare and Medicaid Services (CMS) medicaid medically unlikely edit (MUE) table. If CMS updates the MUE list, the update will take precedence over this policy. The following applies to ABA CPTs:

| CPT | Maximum Units Allowed |
|---|---|
| 97151 | 32 |
| 97152 | 16 |
| 97153 | 32 |
| 97154 | 18 |
| 97155 | 24 |
| 97156 | 16 |
| 97157 | 16 |
| 97158 | 16 |
| 0362T | 16 |
| 0373T | 32 |

IV. Treatment codes are based on daily total units of service in 15-minute increments. A unit of time is attained when the mid-point is passed. The following are time interval examples:

| Unit(s) | Number of Minutes |
|---|---|
| 1 unit | ≥8 - 22 minutes |
| 2 units | ≥23 - 37 minutes |
| 3 units | ≥38 - 52 minutes |
| 4 units | ≥53 - 67 minutes |
| 5 units | ≥68 - 82 minutes |
| 6 units | ≥83 - 97 minutes |
| 7 units | ≥98 - 112 minutes |
| 8 units | ≥113 - 127 minutes |

## F. Related Policies/Rules

Behavioral Health Service Record Documentation Standards
Medical Records Documentation for Practitioners
Medical Necessity Determinations

## H. Review/Revision History

| Date | | Action |
|---|---|---|
| **Date Issued** | 07/17/2024 | New policy. Approved at Committee. |
| **Date Revised** | | |
| **Date Effective** | 01/01/2025 | |
| **Date Archived** | | |

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