MEDICAL POLICY STATEMENT Wisconsin Marketplace	
Policy Name & Number	**Date Effective**
Applied Behavior Analysis for Autism Spectrum Disorder-WI MP-MM-1640	12/01/2024
Policy Type	
MEDICAL	

Medical Policy Statements 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 or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

Medical Policy Statements do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced in the Medical Policy Statement. Except as otherwise required by law, if there is a conflict between the Administrative Policy Statement and the plan contract, then the plan contract 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.

Common Ground Healthcare Cooperative (CGHC) follows state law and guidelines in the provision of ABA services, which are based on a diagnosis from the *DSM-5-TR*. Severity levels are divided into 2 domains, social communication and restricted, repetitive behaviors, defined 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 limited initiation of social interactions,	Inflexibility of behavior, extreme difficulty coping with change, or other restricted/ repetitive behaviors markedly interfere with functioning in all spheres.

substantial support”	and minimal response to social overtures from others.	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.

Social skills instruction is an important component of management of the diagnosis. Although additional studies are necessary, a 2012 meta-analysis of five randomized trials (196 participants) found evidence that participation in social skills groups improved overall social competence and friendship quality in the short term. A 2020 study demonstrated efficacy of a modified group cognitive behavioral therapy program in children delivered in a community context. A 2021 study demonstrated benefits of group cognitive behavioral treatment in adolescents diagnosed with autism and intellectual disabilities. As children near entry in a public or private school system, research supports the use of group therapy for school readiness and improved social skills. Training must be an integral component of the management of the underlying disorder and include clearly defined goals, teach desired behaviors, provide prompting for natural display of desired behaviors, provide reinforcement of demonstrated behaviors, and include practice of desired behaviors with goals of generalizability outside the therapeutic setting (eg, impairments in social-emotional reciprocity, restrictive or obsessional interests, aggressive behaviors).

As the child becomes eligible for school-based services (the age varies depending upon the state), the public school system becomes responsible for the provision of services and education. The services provided are outlined in an individualized education program (IEP), which is reviewed at a minimum of once a year, for children eligible. ASD services do not include education services otherwise available through a program funded under 20 US Code Chapter 3, section 1400 of the Individuals with Disabilities Education Act (IDEA). Congress reauthorized the IDEA in 2004 and most recently amended the IDEA through Public Law 114-95, Every Student Succeeds Act, in December 2015.

C. Definitions

- **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 or paraprofessional supervised appropriately according to Wisconsin Insurance Regulation 3.36.
- **Medically Unlikely Edit (MUE)** – Maximum units of service for 1 Current Procedural Terminology (CPT) code a provider can report for 1 member on 1 date of service.
- **SMART Goals** – Goals that are specific (S), measurable (M), attainable (A), relevant (R), and time-bound (T).
- **Standardized Diagnostic Assessment Tools** – Direct assessment, 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. Members and providers must adhere to the associated Plan's Certification of Coverage document and schedule of benefits.

B. 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. Treatment should not be more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results.

C. 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.

D. Treatment goals and intensity will be based on individual needs and progress in treatment with a focus on remediation of symptoms.

E. The member's treatment record (eg, plans of care, treatment plans, behavior support plans, functional assessments, daily service notes, progress notes)

must be completed by the provider or practitioner, signed by the parent or legal guardian (if minor age) or by the member if applicable, and submitted to CGHC prior to claim submission. Claims will not be accepted without accompanying signed treatment documentation.

II. Initiation of ABA Services
  A. Documentation: CGHC must receive documentation that confirms the following medical criteria:
    1. definitive, primary diagnosis of ASD made by 1 of the following practitioners upon evaluation independent of the ABA provider and with a relationship with the member:
      a. child and adolescent psychiatrist
      b. psychologist
      c. child neurologist
      d. developmental pediatrician
    2. standardized diagnostic assessment tools used as part of a referral for 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, signed by the parent/caregiver 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, graphs and current 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 2 successive 6-month authorization periods 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 efficacy of services for member progress.

V. Parent/Caregiver Training

Training will evolve as goals are met. Parent/caregiver must be actively working on at least 1 unmet goal. ABA services must include documentation of the following:

A. Understanding/agreement to comply with the requirements of treatment
B. how the parent/caregiver(s) will be trained in skills that can be generalized to the home and other environments
C. methods by which parent/caregiver(s) will demonstrate trained skills
D. barriers to parent involvement and plans to address (eg, are treatment goals addressed when professionals are not present, overall skill abilities).
E. time involvement, including any materials or meetings occurring on a routine basis

VI. Telehealth

Telehealth services may be provided when appropriate. 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.

Providers utilizing telehealth for the delivery of services must make decisions that are consistent with best, currently available evidence and clinical consensus. Clinical rationale must consider assessed needs, strengths, preferences, and available resources of members and caregivers. The same professional ethics governing in-person care must be followed and limitations considered, including interstate licensure challenges, state regulatory issues, member or caregiver discomfort with technology, technology limitations, and cultural acceptance of virtual visits. Providers must identify protocols for clinical appropriateness (eg, risk assessment, safety planning, patient/caregiver characteristics), ensure therapeutic benefit for recipients, and ensure provider competence of delivering care via telehealth modalities. Peer reviewed studies and other best evidence literature provides guidance on appropriate screeners and questionnaires for use in the determination of appropriateness of telehealth services for particular clients.

VII. 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.

A. Member records should contain the following documentation:

1. presenting problem, including referral reason, relevant diagnoses and any recommendations for ABA therapy rendered by an appropriate professional
2. service note for each service contact
3. any shared fee information with member/family in compliance with applicable laws, regulations and BACB ethical standards
4. treatment plan and functional assessment on which behavior plan is based
5. any data collected to ascertain efficacy of services and 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. Minimum documentation requirements for all services rendered include
   1. name of provider organization clearly visible on the record
   2. member's name on each page (ie, legal name)
   3. date of birth or unique identifier
   4. date and location of rendered service
   5. date of note creation if different from date of rendered service
   6. start and stop times including any pauses in services (must indicate time paused and time resumed)
   7. type/code of service provided
   8. rendering provider's name, credentials, and dated signature
   9. identification of others present, including the relationship to the member and the number of individuals participating in any group sessions
   10. summary of session activity that directly relates to the POC & client response to interventions
   11. addendum information, if applicable, including a clear reference of the clinical note it is intended to supplement, date completed and signature with credentials

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. CGHC 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 BACB 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 and 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. If there are any discrepancies with supervision documentation, the associated claims are subject to recoupment.

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)

E. CGHC supports BACB published ethical codes related to supervision for the provision of services to clients, including, but not limited to
1. Behavior analysts (BA) are knowledgeable about and comply with all applicable supervisory requirements (eg, BACB rules, licensure requirements, funder and organization policies), including those related to supervision modalities and structure.
2. BAs supervise and train others only within an individual identified scope of competence.
3. BAs take on only the number of supervisees allowing effective supervision and training. When a threshold volume for providing effective supervision has been met, documentation of this self-assessment and communication of results to employer(s) and relevant parties must occur.
4. BAs are accountable for supervisory practices and professional activities (eg, client services, supervision, training, research activity, public statements) of supervisees occurring as part of that relationship.
5. BAs ensure that documentation, and the documentation of supervisees or trainees, is accurate and complete.
6. BAs deliver supervision and training in compliance with applicable requirements (eg, BACB rules, licensure requirements, funder and organization policies) and design and implement supervision and training procedures that are evidence based, focus on positive reinforcement, and are individualized for each supervisee and circumstances.
7. BAs actively engage in continual evaluation of supervisory practices using feedback from others and client and supervisee outcomes. Self-evaluations are documented and timely adjustments made to supervisory and training practices as indicated.

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. Additionally, the BACB publishes information

regarding the structure of supervision and parameters for group and individual supervision in the *RBT Handbook*.

2. An RBT certified by the BACB may provide ABA under the supervision of an independent practitioner if 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, if applicable.
4. CGHC will allow providers 60 days from the date of hire for RBTs to complete the RBT credentialing process with the BACB.

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), amended through Public Law 114-95, the Every Student Succeeds Act
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. CGHC reserves the right to request supervision documentation, particularly related to telehealth services.

III. Providers cannot submit multiple dates of service on a single claim line. Each claim line must be specific to a single date of service and the units provided on that single date of service.

IV. CGHC 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

V. 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

G. Review/Revision History

	Date	Action
Date Issued	08/14/2024	New policy. Approved at Committee.
Date Revised	09/25/2024	Out of cycle review. Added D.I.E., VII.B, E.III. Updated references. Approved at Committee.
Date Effective	12/01/2024	
Date Archived		

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