



HSCSN

HSCSN Internal Policy

POLICY NAME: Applied Behavior Analysis (ABA) Policy

POLICY ID: UM_21

POLICY GROUP: Utilization Management

POLICY LAST UPDATED DATE:

POLICY EFFECTIVE DATE: 06/16/2025

06/16/2025

I. PURPOSE/SCOPE

This policy supports governance of HSCSN's delivery of quality services to its enrollees while ensuring compliance with regulations and implementation of industry-specific standards.

II. POLICY STATEMENT

Summary

Autism Spectrum Disorder (ASD) is a developmental disorder that affects the brain's normal development of social and communication skills. ASD occurs in all racial, ethnic, and socioeconomic groups, but is almost five times more common among boys than among girls. In 2023, Centers for Disease Control (CDC) estimated that about 1 in 36 children have been identified with ASD. ASD is a "spectrum disorder" because ASD affects each person differently, and symptoms can range from very mild to severe. People with ASD share some similar symptoms, such as problems with social interaction; but there are differences in when the symptoms start, how severe they are, and their exact nature.

This policy is a guideline for reviewing authorization requests for Applied Behavior Analysis (ABA), a therapy commonly used for treatment of autism spectrum disorders. Given the specialty healthcare needs of the HSCSN covered population, this policy is to be used as supplemental guidance to HSCSN's medical necessity criteria. This allows enrollees who fall outside of HSCSN contracted medical necessity criteria due to specific age or diagnostic criteria limitations to be subject to medical necessity review and coverage when clinically indicated for ABA services.

III. PROCEDURE

Definitions

Adverse Benefit Determination [C.3.14]: In the case of a Contractor or any of its Providers, Adverse Benefit Determination means any of the following per 42 C.F.R. § 438.400:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirement for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service

- The failure to provide services promptly as defined by the District; or
- The failure of the Contractor to act within the timeframes for the resolution and notification of Grievances and Appeals; and
- The denial of an enrollee's request to dispute a financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Applied Behavior Analysis (ABA) [C.3.19]: Principles and techniques used in the assessment, treatment, and prevention of challenging behaviors and the promotion of new desired behaviors as delivered by a Board-Certified Behavior Analyst (BCBA), Other Licensed Provider (OLP), Board Certified assistant Behavior Analyst (BCaBA) under the appropriate supervision, or a Registered Behavior Technician (RBT) under the appropriate supervision.

Continuing Service Review: Re-authorization or requests for continuation of services are reviewed as pre-service standard requests in terms of classification and timeframe.

Denial of Services [C.3.65]: An adverse decision in response to an Enrollee's or Provider's request for the initiation, continuation, or modification of treatment. A denial may be either wholly or partially adverse to the Provider or Enrollee. The failure to decide on a request for treatment within the timeframes governed by the Agreement constitutes a denial of services. A denial includes complete or partial disapproval of treatment requests, a decision to authorize coverage for treatment that is different from the requested treatment, or a decision to alter the requested amount, duration, or scope of treatment. A denial also constitutes an approval that is conditioned upon acceptance of services in an alternative or different amount, duration, scope, or setting from that requested by the Provider or Enrollee. Approval of a requested service that includes a requirement for a continued service review by the Contractor during the authorized period does not constitute a denial. All denials are considered Adverse Benefit Determinations for purposes of Grievances and Appeals.

InterQual® Criteria: An evidence-based clinical decision support solution for payers, providers, and government agencies who want to help ensure clinically appropriate medical utilization decisions.

Medically Necessary [C.3.174]: Services for individuals that promote normal growth and development and prevent, diagnose, detect, treat, ameliorate the effects of a physical, mental, behavioral, genetic, or congenital condition, injury, or disability and following generally accepted standards of medical practice, including clinically appropriate, in terms of type, frequency, extent, site, and duration and considered effective for the Enrollee's illness, injury, disease, or physical or mental health condition.

Details

1) Applied Behavior Analysis (ABA)

- A. A specific treatment approach for use by enrollees diagnosed with Autism Spectrum Disorder (ASD). ABA has been shown to effectively reduce maladaptive behaviors and increase adaptive behaviors and is, therefore, a covered medical benefit for HSCSN enrollees with ASD.
- B. Enrollees with ASD that would appropriately receive this treatment include those engaged in early intervention services and those with severely challenging behaviors that are significantly interfering with home or community activities. ABA treatment may be appropriate if less intensive behavioral treatment or other therapy has not been sufficient to reduce interfering behaviors, to increase pro-social behaviors, or to maintain desired behaviors.

- C. Documentation of the goals, objectives, and progress specific to parent and/or caregiver involvement in the ABA treatment, skill development, and continued use of the strategies outside of the formal sessions is important for the success of the treatment in the long term.
- D. The individual ABA treatment plan is developed by a Board-Certified Behavior Analyst (BCBA). One-on-one sessions are provided by a Registered Behavior Technician (RBT) or BCaBA, (both under the supervision of the BCBA). The BCBA may also provide one-on-one sessions. Services range in hours of Enrollee contact per week based on the severity of symptoms and intensity of treatment.
- E. Provision of Supervision of the RBT and BCaBA by the BCBA is a component of the standard provision of treatment services and is not separately reimbursed by HSCSN. Per governing bodies for BCBA's (e.g., Behavior Analyst Certification Board, BACB or Behavioral Intervention Certification Council, BICC) practice, the general standard is provision of 2 hours of supervision for every 10 hours of direct treatment by the RBT or BCaBA.
- F. The BCBA may provide and bill for the provision of direct ABA services, not provided at the same time as direct care by RBT or BCaBA.
- G. Treatment may be provided in a variety of settings, such as in the home, in the community, or at an ABA treatment center. ABA services covered by HSCSN are most typically delivered by a contracted and credentialed provider in a home or community setting. Services provided in a school setting are distinct and separate from those covered by the health plan and are typically covered by the educational system's special education resources as part of the Individualized Education Plan (IEP) per Child and Adolescent Supplemental Security Income Program (CASSIP) contract.
- H. This policy applies to ABA evaluation and treatment services provided to HSCSN enrollees in person and via telehealth.

2) General Authorization Guidelines

- A. HSCSN will cover one episode of ABA evaluation annually without prior authorization. Prior authorization is required when more than one episode of ABA evaluation is requested per rolling 12-month period.
- B. ABA treatment delivered by direct care or via telehealth requires prior authorization.
- C. ABA by telehealth is appropriate when the goals established in the treatment plan can be delivered in this format.
- D. Consistent with standards of practice, having more than one RBT, BCaBA's or BCBA delivering services at the same time would be a duplication.
- E. Consistent with standards of practice supervision of RBT's and BCaBA's by BCBA's is expected. This is expected regardless of payment set through contracting.
- F. Consistent with standards of practice, supervision of parent training is expected. This is expected regardless of payments set through contracting.
- G. Treatment schedules are to be included in the treatment plan and should not disrupt regular school attendance for a school-age enrollee.
- H. Continued Service Review requests for ABA treatment require prior authorization.
- I. Authorizations shall be provided for 6 months at a time unless there is a clinical indication to justify modification of this duration.

- J. ABA Providers can request an increase or decrease in weekly hours during the authorization period. A request for a change in weekly hours must be accompanied by clinical documentation to support the request.
- K. An assessment of the effectiveness of the behavioral intervention plan should be documented at the end of each authorization period; specifically, the ABA Provider must show measurable changes in the frequency, intensity and/or duration of the targeted behaviors. These measurable changes should be graphed with dated data points that reflect treatment over time.
- L. If the enrollee shows no meaningful changes after a period of 6 months of optimal treatment, then ABA will no longer be considered medically necessary.
- M. Optimal treatment means that a well-designed set of interventions are delivered in a reliable fashion by the ABA Provider without significant interfering events, such as serious physical illness, major family disruption, changes of residence, etc. Failure of the enrollee's caregivers or support system to reliably implement the intervention plan shall not be considered justification for continued treatment.
- N. For changes to be meaningful they must be maintained beyond the end of the actual treatment session. Behavioral changes should generalize outside of the treatment setting to the enrollee's residence and to his/her larger community. For this to occur, the active involvement of parents/caregivers is necessary.
- O. Exclusions/Limitations:
Any of the following criteria are sufficient for exclusion from initiating or continuing ABA treatment.
 1. The individual has medical conditions or impairments that would prevent beneficial utilization of services.
 2. Services in a facility or hospital setting
 3. The individual is receiving an ongoing HSCSN specifically covering behavioral health in-home services or services similar to ABA treatment for behavior management.
 4. The individual is receiving Personal Care Aide services to address supports needed specific to activities of daily living. PCA is not a behavioral treatment service and does not provide an equivalent service to ABA. The ABA treatment plan may include goals and objectives related to improvements with ADLs as part of the treatment similar to those expected to be addressed through PCA.
 5. The services are primarily for school or educational purposes. HSCSN does not authorize ABA in lieu of school based services.
 6. The treatment proposed in the ABA treatment plan is investigational or unproven, including, but not limited to facilitated communication, Auditory Integration Therapy (AIT), or Holding Therapy.

3) Medical Necessity Criteria for ABA Evaluation

- A. The request for ABA Evaluation is made by a treating Medical Doctor (MD), Doctor of Osteopathy (DO), or Nurse Practitioner (NP).
- B. Enrollee has a diagnosis of ASD as reflected by International Classification of Disease (ICD) 10 code F84.0. This diagnosis has been documented in the enrollee's medical record.

- C. The diagnosis in (1) above is made by a licensed physician or psychologist experienced in the diagnosis and treatment of autism spectrum disorders with developmental or child/adolescent expertise.
- D. If the enrollee does not have an ASD diagnosis, the enrollee may have an ICD-10 diagnosis of a neurodevelopmental disorder with behavioral presentations similar to ASD which would be responsive to ABA treatment interventions. These may include but are not limited to: Fragile X, Tuberous Sclerosis, Smith Magenis. Secondary review is required of all requests for ABA evaluation when an ASD diagnosis is not present
- E. Required clinical information for request of an ABA Evaluation:
 - 1. Enrollee's diagnoses
 - 2. Enrollee's current behavioral problems to be addressed by ABA treatment.
- F. Details about the impact of current behavior problems on the enrollee's daily functioning. The Enrollee exhibits atypical or disruptive behavior that significantly interferes with daily functioning and activities or that poses a risk to the enrollee, or others related to aggression, self-injury, property destruction, etc.
- G. There is potential for improvement of their atypical or disruptive behavior.
- H. For enrollees 3 years, 11 months and younger receiving Early Intervention (EI), additional information needed to make a medical necessity determination includes either a copy of the Individual Family Support Plan (IFSP) if available, or summary of current EI interventions and supports should be included with the request.
- I. For enrollees 4 years and older, additional information needed to make a medical necessity determination includes either a copy of the Individual Educational Plan (IEP), if available, or summary of current interventions and supports should be included with the request. If no IEP is available, an explanation as to why it is not included should be provided.
- J. ABA Evaluation Report Requirements
 - 1. The ABA Evaluation is completed by a BCBA.
 - 2. The evaluation report is completed and signed by the BCBA.
 - 3. All active diagnoses for the enrollee are included in the evaluation report.
 - 4. All past and current therapy services, including but not limited to speech and language therapy or occupational therapy, are included in the evaluation report.
 - 5. Details regarding the history of past ABA treatment are included in the evaluation report.
 - 6. Details regarding the enrollee's current symptoms and their severity are provided in the evaluation report.
 - 7. Treatment goals to address the enrollee's current symptoms and their severity are provided in the evaluation report.
 - 8. Recommendation for the number of hours per week of ABA treatment, with corresponding Current Procedural Terminology (CPT) Codes, to address treatment goals are included in the evaluation report.
 - 9. The printed name and signature of the BCBA submitting the evaluation report is included in the evaluation report.
 - 10. ABA Evaluation reports are considered current and representative of the enrollee's functioning for 90 days. The evaluation results drive the treatment plan. The treatment plan incorporates ongoing assessment and updates. If treatment begins within 90 days of the evaluation, it is not

expected that another evaluation would be needed unless the enrollee's condition changes.

4) Medical Necessity Determination for ABA Treatment

A. Initial Review:

1. The Utilization Management Reviewer (UMR) will review the initial ABA evaluation report and accompanying documents to make a medical necessity determination per HSCSN policy UM_09 Authorization of Health Services. The UMR will review the request using InterQual® Criteria, specifically, InterQual® BH: Behavioral Health Services, Applied Behavior Analysis (ABA) Program.
2. If medical necessity criteria are met upon review, an approval is rendered, and initial authorization process completed per UM_09.
3. In the event the UMR is unable to make a medical necessity determination, the request will be submitted to the Medical Reviewer for second level review to make a determination.
4. If the Second Level Reviewer determines medical necessity is met, an approval for the service will be rendered.
5. If the Second Level Reviewer determines medical necessity is not met for the requested services, an adverse benefit determination will be rendered per HSCSN policy UM_09 Authorization of Health Services.

B. Continued Service Review:

1. The UMR will review requests for continued service and all accompanying documents to make a medical necessity determination per HSCSN policy UM_09 Authorization of Health Services.
2. If medical necessity criteria are met upon review, an approval is rendered, and the continued service authorization process is completed per HSCSN policy UM_09 Authorization of Health Services.
3. In the event the UMR is unable to make a medical necessity determination, the request will be submitted for second level review to make a determination.
4. The Second Level Reviewer will review all available clinical information and make a medical necessity determination.
5. If the Second Level Reviewer determines medical necessity criteria is met an approval for the service will be rendered.
6. If the Second Level Reviewer determines medical necessity is not met for the requested service per InterQual® Criteria, specifically, InterQual® BH: Behavioral Health Services, Applied Behavior Analysis (ABA) Program, or this policy (UM_21) an adverse benefit determination will be rendered per HSCSN policy UM_09 Authorization of Health Services.

5) Medical Necessity Determination for ABA Treatment for Enrollees **outside** of the age range (18 months to 12 years) of InterQual® Criteria, specifically, InterQual® BH: Behavioral Health Services, Applied Behavior Analysis (ABA) Program.

A. Authorization of an ABA Evaluation follows section 3 above.

B. Initial Review (Section 4 above):

1. When the UMR cannot apply the InterQual® Criteria, specifically, InterQual® BH: Behavioral Health Services, Applied Behavior Analysis (ABA) Program due to the Enrollee's age, they will review for medical necessity under this policy, UM 21, Applied Behavioral Analysis.

2. If Unable to make a medical necessity determination based on the available clinical information the Utilization Management Reviewer will send the request for second level review per standard UM _09 Authorization Policy process.
 3. If the Second Level Reviewer determines medical necessity is met an approval for the service will be rendered.
 4. If the Second Level Reviewer determines medical necessity is not met for the requested service, an adverse benefit determination will be rendered based on criteria in Section 4, Medical Necessity Criteria; all available clinical information; and application of community practice standards.
 5. The Second Level Reviewer will follow HSCSN policy UM_09 Authorization of Health Services when rendering the decision.
- C. Continued Service Review:
1. When the UMR cannot apply the InterQual® Criteria, specifically, InterQual® BH: Behavioral Health Services, Applied Behavior Analysis (ABA) Program due to the Enrollee's age, they will review for medical necessity under this policy, UM 21, Applied Behavioral Analysis.
 2. If medical necessity criteria are met upon UMR review, an approval is rendered, and authorization process completed per UM_09.
 3. If the UMR is unable to make a medical necessity determination based on the available clinical information the Utilization Management Reviewer will send the request for second level review per standard UM _09 Authorization Policy process.
 4. The Second Level Reviewer will review all available clinical information and apply criteria in Section 4, Medical Necessity Criteria, using all available clinical information and application of community practice standards/guidelines where applicable.
 5. If the Second Level Reviewer determines medical necessity is met, an approval for the service will be rendered.
 6. If the Second Level Reviewer determines medical necessity is not met for the requested services, an adverse benefit determination will be rendered based on criteria in Section 4, Medical Necessity Criteria; all available clinical information; and application of community practice standards/guidelines where applicable.
 7. The Second Level Reviewer will follow HSCSN policy UM_09 Authorization of Health Services when rendering the decision.

IV. ACCOUNTABLE EXECUTIVE

Accountable Executive(s): Levey, Eric

Committee(s) Responsible for Review: Benefits and Utilization Management Committee

V. APPROVAL

Approved by:

Accountable Executive

Date

VI. REFERENCES

Dates:

Created: 03/22

Reviewed: N/A

Revised: 03/22, 03/24, 07/24, 06/25

Committee Approval: 06/16/2025 - Benefits and Utilization Management Committee (BUMC)

Effective: 06/16/2025

References:

NCQA Standards: N/A

CN Documents/Policies: N/A

CASSIP Contract Sections: C.5.53.2

Federal Regulations: N/A

District Regulations: N/A

Transmittals: N/A

Internal Policies: UM_09

Internal Documents: N/A

Committees: Benefits and Utilization Management Committee (BUMC)

References

Please note that the below is not an exhaustive list of references.

- American Academy of Child and Adolescent Psychiatry. Practice parameters for the assessment and treatment of children, adolescents, and adults with autism and other pervasive developmental disorders. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2014; 53: 237-257.
- American Academy of Child and Adolescent Psychiatry. Practice parameters for the assessment and treatment of children, adolescents, and adults with autism and other pervasive developmental disorders. *JAmAcadChildAdolescPsychiatry*. 1999;38 (suppl):32S-54S.
- American Academy of Pediatrics. (2010). Reaffirmed September 2010. Clinical Report: Management of Children With Autism Spectrum Disorders. *Pediatrics*, 120(5), 1162–1182.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders, Fourth Edition (Text Revision)*. Washington, DC: American Psychiatric Association.
- Anthem BlueCross BlueShield. (2012). Behavioral Health, Medical Necessity Criteria.
- Brereton, A.V., Tonge, B.J. and Einfeld, S.L. (2006). Psychopathology in children and adolescents with autism compared to young people with intellectual disability. *Journal of Autism and Developmental Disorders*, 36 (7), 863–870.

- Centers for Disease Control (CDC). Prevalence of autism spectrum disorders—Autism and Developmental Disabilities Monitoring Network, 14 sites, United States, 2008. *MMWR* 2012;61(No. SS03):1-19.
- Centers for Disease Control (CDC). Prevalence and Characteristics of Autism Spectrum Disorder Among Children Aged 8 Years — Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2018. *MMWR* 2021; 70 70(11);1–16.
- Centers for Disease Control (CDC). Prevalence and Characteristics of Autism Spectrum Disorder Among Children Aged 8 Years — Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2020. *MMWR* 2023; 72(2);1–14.
- Cigna. (2012). Cigna Medical Coverage Policy: Autism Spectrum Disorders/Pervasive Developmental Disorders: Assessment and Treatment.
- Cohen, D., Pichard, N., Tordjman, S., Baumann, C., Burglen, L., Excoffier, E., Lazar, G., Mazet, P., Pinquier, C., Verloes, A., and Heron, D. (2005). Specific genetic disorders and autism: Clinical contribution towards their identification. *Journal of Autism and Developmental Disorders*, 35(1): 103-116.
- Granpeesheh, D., Tarbox, J., and Dixon, D.R. (2009). Applied behavior analytic interventions for children with autism: a description and review of treatment research. *Annals of Clinical Psychiatry*, 21(3), 162-173.
- Hsiao, E.Y. and Patterson, P.H., (2012). Placental regulation of maternal-fetal interactions and brain development. *Developmental Neurobiology*, 72(10), 1317-1326.
- Hyman SL, Levy SE, Myers SM, AAP Council On Children With Disabilities, Section On Developmental And Behavioral Pediatrics. Identification, Evaluation, and Management of Children With Autism Spectrum Disorder. *Pediatrics*. 2020;145(1): e20193447
- Lampi, K.M., Lehtonen, L., Tran, P.L., Suominen, A., Lehti, V., Banerjee, P.N., Gissler, M., Brown, A.S., and Sourander, A. (2012). Risk of autism spectrum disorders in low birth weight and small for gestational age infants. *Journal of Pediatrics*, 161(5), 830-836.
- Landrigan, P.J. (2010). What causes autism? Exploring the environmental contribution. *Current Opinion in Pediatrics*, 22(2):219-25.
- Leyfer, O.T, Folstein, S.E., Bacalman, S. et al., (2006). Comorbid psychiatric disorders in children with autism: interview development and rates of disorders. *Journal of Autism and Developmental Disorders*, 36 (7), 849–861.
- Lord, C., Risi, S., DiLavore, P.S., Shulman, C., Thurm, A., and Pickles, A. (2006). Autism from 2 to 9 years of age. *Archives of General Psychiatry*, 63(6):694-701.
- Myers, S.M., Johnson, C.D., and The Council on Children with Disabilities. (2007). From the American Academy of Pediatrics: Management of Children with Autism Spectrum Disorders. *Pediatrics*, 120(5), 1162-1182.
- National Research Council. (2001). *Educating Children with Autism*. Washington, DC: National Academy Press.
- Ozonoff, S., Young, G.S., Carter, A., Messinger, D., Yirmiya, N., Zwaigenbaum, L., Bryson, S., Carver, L.J., Constantino, J.N., Dobkins, K., Hutman, T., Iverson, J.M., Landa, R., Rogers, S.J., Sigman, M., and Stone, W.L. (2011). Recurrence risk for autism spectrum disorders: A Baby Siblings Research Consortium study. *Pediatrics*, 128: e488-e495.
- Reichow B, Barton EE, Boyd BA, Hume K. (2012). Early intensive behavioral intervention (EIBI) for young children with autism spectrum disorders (ASD).

Cochrane Database of Systematic Reviews, Issue 10. Art. No.: CD009260. DOI: 10.1002/14651858.CD009260.pub2.

- Tufts Health Plan. (2011). Autism Professional Payment Policy. Massachusetts and Rhode Island: Tufts Health Plan.