Healthy Blue — Medicaid UM Guideline

Subject: Autism Spectrum Disorder Services
Status: Active
Current Effective Date: 07/01/2017
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Description

Adaptive Behavioral Treatment (ABT) is described as Intensive Behavioral Intervention (IBI) or Applied Behavioral Analysis (ABA) for Autism Spectrum Disorder (ASD).. In this document, the term 'ABT,' which includes services such as ABA and IBI, refers to services provided as part of ABA and IBI.

Services to treat ASD, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, are provided to eligible Medicaid beneficiaries 0 to 21. ASD services must be recommended by a Physician, Licensed Psychologist or a Licensed Psycho-Educational Specialist (LPES) within his or her scope of practice under South Carolina state law to prevent the progression of ASD, prolong life, and promote the physical and mental health and efficiency of the individual. These services may be provided in the beneficiary's home, clinical setting, or other settings as authorized.

A Licensed Psychologist, Developmental Pediatrician or a LPES certified by the South Carolina Department of Education to perform such evaluations, and acting within the scope of their competency, must certify and document through a comprehensive psychological assessment/ testing report that the beneficiary meets the medical necessity criteria for services via a DSM ASD diagnosis. The comprehensive psychological testing assessment/report should include: :

1. A clinical interview with the beneficiary and/or family members or guardians as appropriate.
- 2. A review of the presenting problems, symptoms and functional deficits, strengths and history, including past psychological assessment reports and records.
- 3. Assessments also include a behavioral observation in one or more settings.
- 4. ASD diagnosis from current edition of DSM, including severity levels
- 5. Autism Diagnostic Observation Schedule (ADOS; ADOS-2).
- 6. . At least one of the following:
    - Autism Diagnosis Interview (ADI)
    - Behavior Assessment System for Children (BASC)
    - Childhood Autism Rating Scale (CARS)
    - Gilliam Autism Rating Scale (GARS)
    - Vineland Adaptive Behavioral Scales (Vineland)
    - Social Responsiveness Scale (SRS)
    - A standardized measure of intelligence (e.g., WISC or WAIS, Stanford-Binet, Bayley Scales, etc.)

- Screening checklists (e.g., MCHAT, STAT, ASQ, etc.)
- Social Communication Questionnaire (SCQ)

ASD Treatment Services by a LIP:
ASD Treatment services can only be furnished by a Licensed Independent Practitioner (LIP) via Prior Authorization once an Individualized Plan of Care (IPOC) has been submitted and approved. ASD treatment services are Evidence-Based Practices (EBP) that support the amelioration and management of symptoms specific to the diagnosis of ASD. Direct beneficiary contact (and collaterals as clinically indicated) are necessary for billable ASD Treatment Services.

Allowable EBPs for ASD treatment services by a LIP include:

- Cognitive Behavioral Intervention Package (CBIP)
- Comprehensive Behavioral Treatment for Young Children (CBTYC)
- Language Training (Production)
- Modeling
- Naturalistic Teaching Strategies (NTS)
- Parent Training Package
- Peer Training Package
- Pivotal Response Treatment®
- Schedules
- Scripting
- Self-Management
- Social Skills Package
- Story-based Interventions

ASD Treatment services by an Applied Behavior Analysis Provider:

Assessments are to be completed by a BCBA or BCaBA. Assessments may include direct observation and measurement of beneficiary behavior in structured and unstructured situations, determination of baseline levels of adaptive and maladaptive behaviors and functional behavior analysis.

Assessment for IPOC Development
Behavior Identification Assessment:
A Behavior identification assessment is an initial functional assessment to be completed by a BCBA or a BCaBA under the supervision of a BCBA. The Behavior Identification assessment includes direct beneficiary contact (and collaterals as clinically indicated) in order to identify maladaptive behaviors, complete a mental health evaluation and establish treatment needs and an IPOC.

This service must include at least two of the following assessments:

- Vineland Adaptive Behavior Scales (Vineland)
- Verbal Behavior Milestone Assessment and Placement Program (VBMAPP)
- Peabody Picture Vocabulary Test

- Social Responsiveness Scale
- Assessment of Functional Living Skills (AFLS)
- Essentials for Living (EFL)
- Assessment of Basic Language and Learning Skills (ABBLS)

Treatment services for ABA are provided via a Prior Authorization once an IPOC is submitted and approved. ABA services are furnished by a BCBA-D, a BCBA, a BCaBA or an RBT in accordance with their competency parameters, as per the Behavior Analyst Certification Board (BCAB). BCaBAs and RBTs furnishing services must be under the direction supervision of a BCBA within their scope of competency.

ABA treatment services include:

1. Observational behavioral follow-up assessment – Direct beneficiary contact (and collaterals as clinically indicated) to identify and evaluate factors that may impede adaptive behavior. This service includes a functional assessment of problem behavior based on direct observation data psychological testing, as clinically indicated.
2. Adaptive behavior treatment by protocol – Direct beneficiary contact (and collaterals as clinically indicated) to address the beneficiary's treatment goals
3. Adaptive behavior treatment with protocol modification – Direct beneficiary contact to resolve one or more factors impeding adaptive behavior and may simultaneously instruct a technician and or family/caregiver in the modified treatment goals
4. Family adaptive behavior treatment guidance – Direct contact with the family/caregiver for specialized training and education to assist with the beneficiary's treatment goals and development. The provider observes and trains the family/caregivers on the beneficiary's status, as well as instructs family/caregivers on techniques to promote the child's development.
5. Group adaptive behavior treatment by protocol – direct contact with two or more beneficiaries to address the beneficiary's treatment goals

Clinical Indications

Medically Necessary:

Treatment plan signed and submitted by licensed MD/DO/NP/PA which must include the following required elements:

- Clinical interview with the member and/or family/caregiver
  - Completed psychological testing results performed by a Licensed Psychologist, Developmental Pediatrician or a LPES certified by the South Carolina Department of Education to perform such evaluations, and acting with the scope of their competency
  - DSM-5-TR Criteria met for autism including severity scale
  - Autism Diagnostic Observation Schedule (ADOS; ADOS-2)
  - One of the following standard psychiatric assessments:
    - Behavior Assessment System for Children (BASC)
    - Vineland Adaptive Scale (within 95 percent confidence interval)
    - Autism Diagnostic Interview-Revised (ADI-R)
    - Social Communications Questionnaire (SCQ)
    - Childhood Autism Rating Scale (CARS)

  - Autism Behavior Checklist (ABC)
  - Modified Checklist for Autism in Toddlers (M-CHAT)
  - Gilliam Autism Rating Scale (GARS)
- BCBA/BCaBA assessment and program plan (IPOC) that must include two of the following elements:
  - ABLLS, AFLS, EFL, VB-MAPP, Vineland, Peabody Picture Vocabulary Test, SCQ
  - Behavioral observation in one or more settings, presenting problems, symptoms and functional deficits, anticipated outcomes stated as measurable goals related to each specific problematic behavior or skill deficit (language, imitation, social skills, cooperation, etc.)
  - Achievement timeframes.
  - Submission of signed FCM-287 ABA Service Provider Request form

Recertification Requests
Treatment plan signed and submitted by licensed MD which must include the following required elements:

- BCBA/BCaBA assessment and program plan that must include the following elements:
  - ABLLS, AFLS, EFL or VB-MAPP
  - Anticipated outcomes stated as measurable goals related to each specific problematic behavior or skill deficit (language, imitation, social skills, cooperation, etc.). These will be submitted on a new form currently in development
  - Achievement timeframes
  - Amount and type of parent/caregiver participation, as applicable to member
  - Date of every ninety-day review and annual re-development
  - Signature, title and date by the multidisciplinary team members including the parent and/or caregiver
  - Submission of signed FCM287-ABA Service Provider Request form
  - Depending on the benefit structure, providers may be asked to submit the last two 90-Day Progress Summaries including the following information: specific objective(s) towards which the 90 days has focused, specific treatment activities and interventions, goals that have been met, graphs of goals and objective demonstrating progress, explanation of delayed progress toward goals, amount and time of parent/caregiver participation, summary of treatment plan for the upcoming 90-days and signature and title, and date by the multidisciplinary team members to include the parent and/or caregiver (see Attachment A for examples of graphs)

The IPOC must be completed no later than:

- The tenth/10th business day after an initial assessment meeting with a LIP or a behavior assessment with an ABA provider is completed; **OR**
- If the IPOC is not completed within this time frame, services rendered are not Medicaid reimbursable.

Note: The number of hours allotted for direct treatment with the individual can continue to be up to 40 hours a week. The hours should be reviewed regularly, and adjusted to address the behavioral targets and key functional skills of the individual, based on the results of the assessments mentioned above.

* Systematic and repeated evaluation of developmental status is critical to assessing the effect of therapeutic treatments, including ABT. The use of standardized assessments facilitates the consistent, systematic, and reliable evaluation early in the course of treatment, preferably before initiating ABT, and at regularly scheduled intervals thereafter. The data derived from these assessments is used to inform about

the impact of treatment on the trajectory of the individual's condition, especially documenting improvement.

Reporting/Documentation

The clinical record must contain documentation sufficient to justify Medicaid reimbursement and should allow an individual not familiar with the beneficiary to evaluate the course of treatment.

The beneficiary's clinical record must include, at a minimum, the following documentation:

- A Comprehensive Assessment/Testing Report which establishes medical necessity via an ASD diagnosis.
- A Behavioral Identification Assessment for ABA services.
- Signed, titled and dated IPOC.
- Signed releases, consents, Beneficiary Rights acknowledgment, and confidentiality assurances for treatment.
- Signed, titled and dated clinical service note (CSN) and progress summaries.
- Copies of all written reports, and any other documents relevant to the care and treatment of the beneficiary.
- Consent for treatment that is dates and signed by the beneficiary, parent, legal guardian or primary care giver or legal representative. A new consent should be signed and dated with each authorization
- Transition/discharge planning
- Coordination of care
- Emergency safety interventions

**All ASD treatment services must be documented in CSNs within five (5) business days of their delivery. ABA providers must document in accordance with ABA standards and guidelines. All other providers' CSNs must include the nature of the beneficiary's treatment, any changes in treatment, discharge, crisis interventions and any changes in medical, behavioral or psychiatric status. Documentation must justify the amount of reimbursement claimed to Medicaid.

At minimum, all CSN's requires documentation of the following elements:

- Date
- Face to face time start and end time
- Individuals present during the visit
- Brief description of services provided
- Clinical note on the recipient's behavior
- Place of service/delivery setting
- Any communication with guardians/ caregivers
- Signature of rendering provider with title
- All elements must be documented in legible handwriting
- Corrections to the medical record must adhere to the following guidelines:
    - For paper record corrections draw one line through the error, and write "error", "ER", "mistaken entry" or "ME" to the side of the error in parenthesis. Enter the correction, sign or initial, and date it.

  - Errors cannot be totally marked through; the information in error must remain legible. No correction fluid may be used.
  - For electronic health records, error correction must include date/time stamp and user ID.
- Late Entries should rarely be used, and then only used to correct a genuine error of omission or to add new information that was not discovered until a later date. Whenever late entries are made adhere to the following:
  - Identify the new entry as a "late entry"
  - Include date/time and identify or refer to the date and incident for which late entry is written

The IPOC must be individualized and specify problems to be addressed, goals to be worked toward and the strengths of the beneficiary. The IPOC must be developed prior to the delivery of a service with the full participation of the beneficiary and his or her family. The IPOC must be completed in its entirety and include the following:

- Beneficiary's strengths, needs, abilities and preferences
- Goals and objectives of treatment which tie into the assessment and evaluation results
- Outline to address the assessment needs
- Specific treatment activities and interventions
- Amount and type of parent/caregiver participation, as applicable
- Date of each completed progress summary and annual re-development
- Signature, title, and date by the multidisciplinary team members including parent or caregiver

**The IPOC must be completed no later than the 10th business day after an initial assessment meeting. If the IPOC is not completed within this timeframe, services rendered are not Medicaid reimbursable. The IPOC must be reviewed as part of the regular progress summary and the progress summaries must be completed at least quarterly. A new IPOC must be developed every 12 months.

Coding

Billable Codes[2]:

All Medicaid beneficiaries must be ages 0 to21 and have an established ASD diagnosis to meet medical necessity criteria to receive ASD treatment services.

A licensed psychologist or a school psychologist certified by the South Carolina Department of Education to perform such evaluations and acting within the scope of their competency must certify and document through a Comprehensive Psychological Assessment/Testing Report that the beneficiary meets the medical necessity criteria for services via a DSM or ICD-10 ASD diagnosis. A prior-established diagnosis is also acceptable provided the comprehensive assessment/testing report adheres to the medical necessity guidelines. The following guidelines shall be used to determine medical necessity:

[2] Procedure and HCPC Codes provided by the state of South Carolina

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Service Name	Procedure Code	Qualifications	Frequency Limits
Screening and Diagnositic Assessment Services			
Behavior Identification Assessment	97151	BCBA-D BCBA BCaBA	32 units annually
ASD Treatment Services			
Adaptive Behavior Treatment by Protocol	97153	BCBA-D BCBA BCaBA RBT	160 units per week (in any combination)
Group Adaptive Behavior Treatment by Protocol	97154	BCBA-D BCBA BCaBA RBT	2-6 patients, up to 6 hrs/day
Adaptive Behavior Treatment with Protocol Modifications	97155	BCBA-D BCBA BCaBA	To be rendered at the rate of 10% of weekly therapy hours, up to 64 units per month (in any combination)
Family Adaptive Behavior Treatment Guidance	97156	BCBA-D BCBA BCaBA	96 units annually (up to 24 hours a year
Group Adaptive Behavior Treatment by Protocol	97158	BCBA-D BCBA BCaBA	2 – 6 patients, up to 6 hours a day
Non-ABA Treatment Services	H2019	Licensed Psychologist Licensed Psychoeducational Specialist Licensed Independent Social Worker, Clinical Practice Licensed Marriage and Family Therapist Licensed Professional Counselor	4 units per week

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Discussion/General Information

The clinical approach to a parent's initial complaints about developmental abnormalities is dictated by age. Parents may bring the child in to the physician as young as 12 months, though generally the first contact is around 24 months or later. With children under 24 months, it will be more problematic to arrive at correct and stable diagnosis, delaying an accurate diagnosis. This serves to underline the importance of the physician's skills, knowledge and experience. Parents who already have a child with ASD are often sensitized to early symptoms and these children are often brought in at even earlier ages. The estimated risk for ASD in younger siblings in identified patients is five percent.

Practice parameters for screening: these require immediate further evaluation:

- No babbling by 12 months
- No gesturing by 12 months (pointing, waving bye-bye, etc.)
- No single words by 16 months
- No two-word spontaneous phrases by 24 months
- ANY loss of ANY language or social skills at ANY age (Filipek, Accardo, Baranck, 1999)

The evaluation of individuals who test positive on a specific test or meet the practice parameters should commence a diagnostic evaluation with a complete history and physical examination, performed by a clinician experienced in the evaluation of ASD, in an attempt to determine a working diagnosis. This should include a complete history of the pregnancy, labor and delivery, exposure to toxins, drugs, infections and delivery complications. A full developmental history of all milestones of infant development also needs to be obtained, which would include the assessment of regression for previously learned abilities.

Further testing may include, but not be limited to:

- Vision and audiometric screening
- IQ evaluation
- Speech and language evaluation
- Blood work: CBC, thyroid
- Other labs (as indicated): metabolic studies (amino and organic acids, ammonia, lactate, etc.), cytogenetic studies (high resolution chromosome studies, Fragile X testing, translocation/deletion syndromes, etc.)
- Imaging: MRI of brain (not typically indicated)
- EEG (sleep deprived may be preferred), especially with a history of seizure spectrum behavior
- Consults with psychiatrist, neurologist, pediatrician, psychologist, speech, occupational and/or physical therapist, etc., as indicated

Medical conditions associated with autistic-like behaviors include, but are not limited to:

- Seizure disorders
- Hearing problems
- Fetal alcohol syndrome
- Trisomy 21
- Goldenhar syndrome
- Hypothyroidism

- Phenylketonuria
- Cornelia de Lange syndrome
- Neurofibromatosis
- Tourrette's syndrome
- Dandy-Walker Syndrome
- Myoclonic epilepsy of infancy (Dravet Syndrome)
- Doose syndrome: myoclonic astatic seizures

There is also an emerging literature that suggests international adoption, and perhaps family movement to another language/culture, may severely impact infants, toddlers and preschoolers in the early phases of cognitive language development, such that autistic like behaviors may occur. This may be referred to as a disruption of cognitive language development, as opposed to communicative language development.

ABA for ASD includes efforts to extinguish negative behaviors, and to replace these with positive behaviors by improving skills, based upon Skinnerian concepts of conditioned responses. Another focus would be the development of the ability to generalize concepts already learned to novel situations. Aside from a concentration on the core symptoms, there is a focus on attention and initiation as well. All involve a structured environment, predictable routines, functional as opposed to standardized treatment, a transition plan and significant family involvement. At the initial evaluation, target symptoms are identified, with designated interventions. There is also a need to provide an assessment mechanism at specified intervals.

ABA services for young children are often referred to as Early Intensive Behavioral Intervention (EIBI). EIBI targets cognition, language, social skills, etc. These services have typically been provided to children ages 8 and under for a duration of two to three years. During an average week, these services may be provided for up to 40 hours. Although the literature is clear that 10 hours per week results in a less robust therapeutic response, it remains unclear as to the optimal number of hours/week. After these preschool years, services may be provided by the child's school, as well as in the child's home. For children above the age of 10 years, services requested may focus on the development of social skills. Much of the ABA research has focused on children in the age range 2-7.

Other Therapies for ASD
Other therapies for ASD include, but are not limited to: Auditory Integration Therapy, Facilitated Communication, Developmental Individual-difference Relationship-based (DIR/Floortime) model, Relationship Development Intervention, Holding Therapy, Movement Therapies, Music Therapy, Pet Therapy, psychoanalysis, Son Rise Program, Scotopic Sensitivity Training, Sensory Integration Therapy, Neurotherapy (EEG biofeedback), gluten and casein free diets, mega-vitamin therapy, chelation of heavy metals, anti-fungal drugs for presumed fungal infection and secretin administration. There is insufficient evidence to support efficacy for a few of these treatments and no evidence for the majority. These programs are not considered to be Behavioral Therapy.

Aversive Techniques
Behavioral change techniques should use reinforcement whenever possible with consideration given to the least restrictive techniques possible. When punishment is chosen for a problem behavior, the techniques employed must follow the ethical guidelines dictated by the Behavior Analyst Certification Board. The parent or guardian must provide written consent for use of any techniques that may be considered aversive.

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Definitions

Autism Spectrum Disorder refers to a disorder as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association. This disorder is best characterized as neurobiological disorder of uncertain etiology, with symptom onset in the first years of life. Heritability is polygenic and estimated to be 90 percent. The primary phenomenon in ASD is severe impairment in development of social skills. Other deficits that may be observed include failure to initiate play or social interaction, inability to generalize learned behavior to new situations, failure to share attention with others, poor sleep, temper tantrums, hyperactivity, etc.

Autism is characterized by a triad of deficits in social skills, communication/language abilities and impairments in imaginative play. Additionally, there are often stereotypic behaviors, restricted interests and activities. Significant numbers of patients also experience intellectual disability and, as one would expect, there is a relationship between cognition and response to treatment.

Applied Behavioral Analysis for ASD refers to behavioral modification using ABA techniques, or the Lovaas Method, to target cognition, language and social skills. Techniques used within this paradigm include Discreet Trial Training, Incidental Teaching, Pivotal Response Training and Verbal Behavioral Intervention. ABA service for younger children is often referred to as Early Intensive Behavioral Intervention (EIBI).

Board Certified Behavior Analyst® (BCBA®) refers to the person who is certified by the BACB (Behavioral Analyst Certification Board) and who is responsible for the administration of appropriate assessment tools, plan/notebook development, implementation and oversight, as well as workshop/training and oversight of all staff, reviewing data, updating plan, and troubleshooting. This person also conducts six-month assessments that include the Assessment of Basic Language and Learning Skills (ABLLS)– Assessment of Functional Living Skills (AFLS), Essential for Living (EFL) or Verbal Behavior Milestones Assessment and Placement (VB-MAPP), and a summary of treatment plan goals met and unmet related to specific behaviors, including, but not limited to, language, imitation, social skills, and cooperation, as well as periodic re-assessments of progress and problems noted.

Board Certified Assistant Behavior Analyst® (BCaBA®) refers to the person skilled in ABA techniques and is responsible for assessing progress via weekly monitoring utilizing highly structured formats and data review. BCBAs may delegate services listed above to a BCaBA who has been credentialed and is receiving required supervision. Rendering providers must possess a four-year college degree and may or may not be certified as BCBA. This person ensures that a RBT is well trained and acts as a liaison between the family and treatment team.

Registered Behavior Technician ™ (RBT™) refers to the person trained in ABA techniques who is responsible for working directly with the child and for following a pre-set program plan for implementing skill acquisition and behavior reduction procedures and recording program data

Educational interventions: Learning interventions that assist children with obtaining knowledge and communication through speech, sign language, writing and other methods and social skills. **Note:** Many benefit contracts exclude coverage for services that are educational in nature.

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Websites for Additional Information

South Carolina Department of Health and Human Services www.scdhhs.gov **Accessed August 9, 2023

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Change Log

Status	Date	Action
New	5-3-2017	Created
Approved	6-5-2017	Medical Operations Committee, MOC
Updated	6/24/19	Updated ASD CPT codes
Reviewed and Approved	06/25/2020	Medical Operations Committee, MOC
Reviewed	06/11/2021	Reviewed-no changes
Approved	6/17/2001	Medical Operations Committee (MOC)