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<tr><td> </td><td colspan="2">**Medical Coverage Policy**</td></tr>
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SAHP	IHP	SGC	LGC	SC	ADMIN
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<tr><td rowspan="4">**SHP MCP-012 Applied Behavioral Analysis (ABA)**</td><td>**Effective Date: 09/09/2016**</td></tr>
<tr><td>**Last Revision/Review Date: 09/12/2017**</td></tr>
<tr><td>**Dissemination Date: 09/12/2017**</td></tr>
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DISCLAIMER

This Samaritan Health Plans (SHP) Medical Coverage Policy is intended to facilitate the Utilization Management process. It expresses Samaritan Health Plan's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (i.e., will be paid for by Samaritan Health Plans) for a particular member. The member's benefit plan determines coverage. Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their providers will need to consult the member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this Samaritan Health Plans Medical Coverage Policy (SHPMCP) document and provide the directive for all Medicare members.

Samaritan Health Plan Medical Coverage Policies are not medical advice. Members should consult with appropriate health care providers to obtain needed medical advice, care and treatment.

Samaritan health plans reserves the right to conduct retrospective review for medical necessity, medical appropriateness and/or potential fraud, waste and abuse. Claims may be reviewed for medical appropriateness for the services.

PURPOSE

This SHPMCP establishes guidelines on the requirements for referral and approval of Applied Behavioral Analysis (ABA).

DEFINITIONS

I. **Applied Behavioral Analysis (ABA)** – a process of assessing and modifying behavior for individuals who have autism and other developmental disorders. Interventions occur in the community with the individual and their support system.

The focus is on changing the environment and monitoring the individual's responses to result in improved behavior or learning of life skills.

PROCEDURE

I. Intensive Treatment (EIBI – Early Intensive Behavioral Intervention)
   A. Clinical indications and requirements for admission:
      i. Diagnosis of Autism (DSM-5 299.0; ICD-10 F84.0) or Stereotypic Movement Disorder with Self-Abusive Behaviors due to a Neurological Dysfunction (DMS-5 307.3; ICD-10 F98.4)
      ii. ABA services shall be recommended by a licensed physician, licensed psychologist or licensed mental health practitioner who has experience or training in the diagnosis of autism spectrum disorder and holds at least one of the following educational degrees and valid licensure:
         I. Physician licensed to practice in the State of Oregon;
         II. Psychologist licensed to practice in the State of Oregon;
         III. Mental Health Practitioner licensed to practice in the State of Oregon
      iii. Documentation
         I. Includes
            - An assessment that substantiates the diagnosis of Autism Spectrum Disorder (ASD) or Stereotypic Movement Disorder with Self-Injurious Behavior;
            - Description of behaviors considered to have an adverse impact on the individual's development or communication;
            - In the absence of definitive diagnosis of ASD, a list of instruments used to try to substantiate a diagnosis (and scores), and/or clear documentation of self-injurious behavior
         II. Supports and verifies the diagnosis of autism or self-injurious behavior which may include:
            - Notes from well-child visits or other medical professionals;
            - Mental health assessment
            - Results from any additional assessments such as IQ test, speech and language tests, or tests of auditory function
      iv. Licensed physician, psychologist or mental health practitioner who has experience or training in the diagnosis of autism spectrum disorder shall write a referral of ABA treatment which includes:
         I. A diagnosis of autism or self-abusive behavior;

II. A copy of the evaluation and/or documentation described as above;
III. An order for ABA treatment without specifying hours or intensity

v. Medical necessity will be documented in MCG. The clinical indications supported by documentation include:

I. Patient has significant maladaptive behaviors or skills deficits identified and judged to be within the treatment domain of ABA treatments, e.g. self-injury, aggression, or deficits in language, self-care, and socialization;
II. Less intensive behavior treatment or other therapy has been considered or has been insufficient to reduce interfering behaviors, to increase prosocial behaviors or to maintain desired behaviors;
III. Patient is expected to be able to adequately participate in treatment (e.g. sufficient cognitive, language and intellectual capacities)

B. Authorization occurs in up to 6 month increments based on initial and ongoing assessment and progression towards goals/objectives
C. CPT codes used include 0359T-0374T

II. Less Intensive Treatment must be based on individualized determination of medical appropriateness.

A. Interventions include parent training, play/interaction based interventions and joint attention interventions
B. Address core symptoms of autism and/or specific problem areas
C. Medical necessity which meets Oregon Administrative Rules and Prioritized List includes:

i. Does not meet criteria for Intensive Treatment
ii. Intensive Treatment has been completed

III. Continued Stay Criteria for renewal of same level of care

A. One of the following must be met:

i. Patient continues to meet the criteria defined in appropriate admission criteria
ii. New problems or symptoms that meet admission criteria have appeared

B. And one or more of the following must be met:

i. Residual core ASD symptoms are still present despite completion of course of comprehensive therapy
ii. Patient is currently enrolled in comprehensive ABA program but lacks significant progress toward treatment goals (i.e. focused ABA services are added as adjunct to comprehensiveABA program).

iii. Focal deficits are present (e.g. isolated impairment in verbal communication) that are appropriate for targeted behavioral intervention in patients who are not enrolled in comprehensive ABA treatment program.

C. All of the following must be met:

i. Treatment is not making the symptoms persistently worse

REFERENCES

1. Oregon Administrative Rules: 410-172-0650(4)(h) – Prior Authorization, 410-172-0760 - Applied Behavioral Analysis; 410-172-0770 – Individual Eligibility for Applied Behavioral Analysis Treatment; 410-130-0160 - Codes
2. Oregon Prioritized List of Health Services – Behavioral Health Services, Guideline Notes 75 and 126
3. MCG Behavioral Health Care 21st Edition
4. IHN-CCO Contract
5. Oregon Senate Bill 365

Required Review Date: 09/12/19			
Revision #	Approved By / Date	Policy Owner Approved / Date	Revision Description
1	09/09/16	Mental Health Advisory Council	Recommend approval
2	11/08/2016	Quality Management Committee	Reviewed and approved
3	09/12/17	Quality Management Committee	Reviewed and approved. Removed age requirements and updated continued stay criteria.