Clinical Policy: Applied Behavioral Analysis

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Date of Last Revison: 03/24

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This clinical policy outlines the utilization management of authorization requests for applied behavior analysis (ABA) services under the Oklahoma Secretary of State Administrative Rules Title 317. Oklahoma Health Care Authority. Part 30: Applied Behavior Analysis (ABA).

Applied Behavior Analysis (ABA) focuses on the analysis, design, implementation, and evaluation of instructional and other environmental modifications to produce meaningful changes in human behavior. ABA services include the use of direct observation, measurement, and functional analysis of the relations between the environment and behavior.[1]

Policy/Criteria

I. It is the policy of Oklahoma Complete Health and Centene Advanced Behavioral Health that applied behavioral analysis (ABA) is medically necessary when meeting all of the following:

A. Member/Enrollee is <21 years of age with a definitive diagnosis of autism spectrum disorder (ASD), certified by one of the following providers:
   1. Pediatric neurologist or neurologist;
   2. Developmental pediatrician;
   3. Licensed psychologist;
   4. Psychiatrist or neuropsychiatrist;
   5. Other licensed physician experienced in the diagnosis and treatment of ASD;

B. A comprehensive diagnostic evaluation or thorough clinical assessment completed by one of the providers listed in I.A. documents both of the following:
   1. A complete, pertinent medical and social history, including pre-and perinatal, medical, developmental, family, and social elements;
   2. One of the following:
      a. Includes criteria outlined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) to confirm the ASD diagnosis;
      b. Scores from formal diagnostic tests such as one of the following (as applicable). Note: Screening scales are not sufficient to make a diagnosis and will not be accepted as the only formal scale:
         i. Autism Diagnostic Interview-Revised (ADI-R);
         ii. Autism Diagnostic Observation Schedule-2 (ADOS-2);
         iii. Childhood Autism Rating Scale (CARS);
         iv. Other tools with acceptable psychometric properties;

C. There is a reasonable expectation that the member/enrollee will benefit from applied behavioral analysis (ABA) with both of the following demonstrated by the member/enrollee:
   1. The ability/capacity to learn and develop generalized skills to assist with independence;

2. The ability to develop generalized skills to assist in addressing maladaptive behaviors associated with ASD;

D. The member/enrollee is medically stable and does not require 24 hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for individuals with intellectual disabilities (ICF/IID);

E. The member exhibits atypical or disruptive behavior within the last 30 days that significantly interferes with daily functioning and activities such as, but not limited to, one of the following:
   1. Impulsive aggression toward others;
   2. Self-injury behaviors;
   3. Intentional property destruction;
   4. Severe disruption in daily functioning (e.g., the individual's inability to maintain in school, childcare settings, social settings, etc.) due to changes in routine activities that have not been helped by other treatments such as one of the following:
      a. Occupational therapy;
      b. Speech therapy;
      c. Additional psychotherapy;
      d. School or daycare interventions;

F. The focus of treatment is not custodial in nature and does not meet any of the following:
   1. The member/enrollee has reached maximum level of physical or mental function and is not likely to make further significant improvement;
   2. The member/enrollee requires care which is focused on daily living activities. Note: Does not require continuous attention of a trained medical or paramedical personnel;

G. Interventions are intended to strengthen the member/enrollee's and parent(s)/legal guardian's capacity for self-care and self-sufficiency, decreasing the need for additional intervention support in the home;

H. There is no less intensive or more appropriate level of service which can be safely and effectively provided;

I. Request is for one of the following:
   1. Initial request includes all of the following:
      a. A comprehensive behavioral assessment outlining the maladaptive behaviors consistent with the diagnosis of autism spectrum disorder (ASD) and its associated comorbidities includes all of the following:
         i. Information about relevant medical status, prior assessment results, response to prior treatment, and other relevant information gathered from review of records and past assessments;
         ii. Information gathered from interview of family and/or caregivers, rating scales, and social validity measures to assess perceptions of the member/enrollee's skill deficits and behavioral excesses, and the extent to which these deficits impede the daily life of the member/enrollee and the family;
         iii. Direct assessment and observation, including any data related to the identified problem behavior. The analysis of such data serves as the primary basis for identifying pretreatment levels of functioning, developing, and adapting treatment protocols, and evaluating response to treatment and progress towards goals;

iv. A functional behavior assessment (FBA), completed by a board-certified behavior analyst (BCBA) includes all of the following:
    a) Description of the problematic behavior (topography, onset/offset, cycle, intensity, and severity);
    b) History of the problematic behavior (long-term and recent);
    c) Antecedent analysis (setting, people, time of day, and events);
    d) Consequence analysis;
    e) Impression and analysis of the function of the problematic behavior;
v. Other supporting assessments, as applicable;

b. Treatment plan is developed from the FBA by a BCBA or a licensed psychologist and there is documentation that the treatment plan meets all the following:
    i. Developed during a one-on-one encounter with the member/enrollee (except in the case of family adaptive treatment guidance);
    ii. Child-centered and based upon individualized goals that are strengths-specific, family focused, and community based;
    iii. Culturally competent and the least intrusive possible;
    iv. Clearly defined, in measurable and objective terms, specific target behaviors;
    v. Identifies the function of the identified maladaptive behavior and includes antecedent interventions, replacement skills to be taught, and modification of consequences;
    vi. Records the frequency, rate, symptom, intensity/duration, or other objective measures of baseline levels;
    vii. Specifies long-term and short-term objectives that are defined in observable, measurable behavioral terms;
    viii. Sets quantifiable criteria for progress;
    ix. Establishes and records behavioral intervention techniques that are appropriate to target behaviors;
    x. Includes training and support to enable parents and other caregivers to participate in treatment planning and successfully reinforce the established treatment plan in the home and community settings;
    xi. Documents planning for transition through the continuum of interventions, services, and settings, as well as discharge criteria;
    xii. Ensures that recommended ABA services do not duplicate, or replicate services received in a member/enrollee's primary academic education setting or provided within an Individualized Education Plan (IEP), Individualized Service Plan (ISP), or any other individual plan of care;
    xiii. Clearly identifies the schedule of services planned and the individuals responsible for delivering the services, including frequent review of data on target behaviors and adjustments in the treatment plan and/or protocols by the BCBA or licensed psychologist as needed;
    xiv. Includes training and supervision to enable board certified assistant behavior analysts (BCaBAs) and registered behavior technicians (RBTs) to implement assessment and treatment protocols;
    xv. Includes care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable;

   c. Documentation that ABA treatment will be delivered or supervised by an ABA credentialed professional and is consistent with ABA techniques. Note: Detailed information about eligible providers can be found here;
2. Service extension request include all of the following:
   a. Criteria noted in section I.A-H continues to be met;
   b. The frequency of the target behavior has diminished since last review, or if not, one of the following has occurred:
      i. Treatment modifications have been implemented;
      ii. Additional assessments have been conducted;
   c. A functional analysis is completed by the provider when no measurable progress has occurred, or it may be requested, and includes all the following information:
      i. The member/enrollee's serious maladaptive target behavioral symptom(s) and causes of the maladaptive behavior;
      ii. Modifications of the current treatment plan to address progress;
      iii. Determines the function a particular maladaptive behavior serves for the member/enrollee in the environmental context;
   d. Appropriate consultations from other staff or experts have occurred (to optimize psychiatric medications and medical treatments to include but not limited to psychiatric consults, pediatric evaluation for other conditions, etc.). Note: ABA providers may be requested to consult with other staff or experts, as applicable;
   e. Interventions have been changed, including the number of hours per week of service, or setting (higher level of care);
   f. Parent(s)/legal guardian(s) have received re-training on any changed approaches to treatment;
   g. The treatment plan documents a gradual tapering of higher intensities of intervention and transitioning to supports from other sources (i.e., schools) as progress allows.

Background

In the state of Oklahoma, applied behavioral analysis (ABA) services are provided under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. The EPSDT program is a comprehensive child-health program, designed to ensure the availability of, and access to, required health care resources and help parents and guardians of Medicaid-eligible children and adolescents use these resources.[1]

Autism spectrum disorder (ASD) is characterized by varying degrees of difficulty in social interaction and verbal and nonverbal communication, and the presence of repetitive behavior and/or restricted interests. Symptom presentation will differ for each individual, therefore, treatment will vary in terms of intensity and duration, complexity, and treatment goals.[2] ABA uses changes in environmental events, including antecedent stimuli and consequences, to produce practical and significant changes in behavior.[1]

Oklahoma Health Care Authority[1]

Title 317:30-5-311 describes eligible providers and requirements.

(a) Eligible ABA provider types include:

(1) Board certified behavior analyst® (BCBA®) - A master's or doctoral level independent practitioner who is certified by the national-accrediting Behavior Analyst Certification Board, Inc.®(BACB®) and licensed by the Oklahoma Human Services' (OKDHS) Developmental Disabilities Services Division (DDS) to provide behavior analysis services. A BCBA may supervise the work of board-certified assistant behavior analysts and registered behavior technicians implementing behavior analytic interventions;

(2) Board-certified assistant behavior analyst® (BCaBA®) – A bachelor's level practitioner who is certified by the national accrediting BACB and certified by OKDHS DDS to provide behavior analysis services under the supervision of a BCBA;

(3) Registered behavior technician (RBT®) - A high school level or higher paraprofessional who is certified by the national accrediting BACB and practices under the close and ongoing supervision of a BCBA. The RBT works under the license number of a BCBA and is primarily responsible for the direct implementation of BCBA designed and prescribed behavior analytic services;

(4) Licensed psychologist - An individual who is licensed and in good standing with the Oklahoma State Board of Examiners of Psychologists and has professional experience in the use of ABA therapy may render behavior analysis services. Refer to OAC 317:30-5-275;

(5) Human services professional - A practitioner who is licensed by the State of Oklahoma pursuant to (A) - (G), and certified by the national-accrediting BACB, and who is working within the scope of his or her practice, to include:

(A) A licensed physical therapist;

(B) A licensed occupational therapist;

(C) A licensed clinical social worker or social worker candidate under the supervision of a licensed clinical social worker;

(D) A licensed speech-language pathologist or licensed audiologist;

(E) A licensed professional counselor or professional counselor candidate under the supervision of a licensed professional counselor;

(F) A licensed marital and family therapist or marital and family therapist candidate under the supervision of a licensed marital and family therapist;

(G) A licensed behavioral practitioner or behavioral practitioner candidate under the supervision of a licensed behavioral practitioner.

Council of Autism Service providers (CASP)[2]

The Council of Autism Service Providers (CASP) has developed guidelines and recommendations that reflect established research findings and best clinical practices. These guidelines focus on the use of ABA as a behavioral health treatment to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual with ASD. ABA includes the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

According to CASP the following are four core characteristics essential to the practice elements of ABA treatment:

1. An objective assessment and analysis of the member/enrollee's condition by observing how the environment affects the member/enrollee's behavior.

2. Importance given to understanding the context of the behavior and the behavior's value to the individual, the family, and the community.
3. Utilization of the principles and procedures of behavior analysis such that the member/enrollee's health, independence, and quality of life are improved.
4. Consistent, ongoing, objective assessment and data analysis to inform clinical decision-making.

American Academy of Pediatrics (AAP)[3]
The AAP recommends that all children be screened for ASD at ages 18 and 24 months, along with regular developmental surveillance. Toddlers and children should be referred for diagnostic evaluation when increased risk for developmental disorders (including ASD) is identified through screening and/or surveillance. Although symptoms of ASD are neurologically based, they manifest as behavioral characteristics that present differently depending on age, language level, and cognitive abilities. Core symptoms cluster in two domains (social communication, interaction, and restricted, repetitive patterns of behavior), as described in the DSM-5TR.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision[4]
The Diagnostic and Statistical Manual of Mental Disorders, list the following as the severity levels for autism spectrum disorders. They are divided into two domains (social communication and social interaction and restrictive, repetitive patterns of behaviors) To fulfill diagnostic criteria for ASD by using the DSM-5 TR, all three symptoms of social affective difference need to be present in addition to 2 of 4 symptoms related to restrictive and repetitive behaviors.

Severity Level	Social Communication	Restricted, repetitive behaviors
Level 3 "Requiring very substantial support"	Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and when he/she does, makes unusual approaches to meet needs only and responds to only very direct social approaches.	Inflexibility of behavior, extreme difficulty coping with change or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changes focus or action.
Level 2 "Requiring substantial support"	Marked deficits in verbal and nonverbal communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interest, and who has markedly odd nonverbal communication.	Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer in a variety of context. 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. For example, a person who is able to speak in full	Inflexibility of behavior cases significant interference with functioning in one or more context. Difficulty switching between activities. Problems of organization and planning hamper independence.

	sentences and engages in communication but who's to and from conversation with others fails, and who attempts to make friends are odd and typically unsuccessful.	

Reviews, Revisions, and Approvals	Revision Date	Approval Date
New policy adapted from Oklahoma Complete Health under the prior authorization requirements outlined in the Oklahoma Administrative Code (OAC) 317:30-3-313 and 317:30-5-314.	03/24	

References

1. Oklahoma Secretary of State Administrative Rules. Title 317. Oklahoma Health Care Authority. Chapter 30. Part 30. Applied Behavior Analysis (ABA) Services. OAC 317:30-5-310 through 317:30-5-316. https://rules.ok.gov/code?q=. Effective September 12, 2022. Accessed March 18, 2024.
2. Council of Autism Service Providers (CASP). Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers (2nd ed.). https://www.casproviders.org/asd-guidelines. Published March 2020. March 18, 2024.
3. American Academy of Pediatrics. Autism Spectrum Disorder. https://www.aap.org/en/patient-care/autism/. Published April 5, 2023. Accessed March 18, 2024.
4. American Psychiatric Association. (2022). Diagnostic and statistical manual of mental disorders (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy,

contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.