KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington

Clinical Review Criteria
Applied Behavioral Analysis Therapy (ABA)

Criteria

For Medicare Members

Source	Policy
CMS Coverage Manuals	Medicare Benefit Policy Manual, Chapter 15 - Covered Medical and Other Health Services
National Coverage Determinations (NCD)	None
Local Coverage Determinations (LCD)	None
Local Coverage Article	None

Non-Medicare Members

- **For patients with a Microsoft contract**, click here to view the criteria.
- **For all other plans where the contract includes coverage for ABA therapy, see below for criteria**
- **For plans without a benefit**, the service is not covered at this time.

For all Kaiser Permanente plans with a benefit (except Microsoft)
ABA requires preauthorization for initial and continued therapy. Specific coverage may be defined in the individual member contract. The following criteria must be met:

1. The member has a diagnosis of an Autism Spectrum Disorder (DSM-V code including severity levels) according to WAC 388-823-0500 by a board-certified neurologist; board-certified psychiatrist; a licensed psychologist; an advanced registered nurse practitioner (ARNP) associated with an autism center, developmental center, or center of excellence; a licensed physician associated with an autism center, developmental center, or center of excellence; or a board certified development and behavioral pediatrician

2. The diagnostic assessment must include **All of the following** elements:
   a. Documentation of formal diagnostic procedures by an experienced clinician (e.g., Autism Diagnostic Interview-Revised, Autism Diagnostic Observation Schedule, diagnostic interview using DSM-V criteria)
   b. Description of how patient's behaviors are having an impact on development, communication or adjustment such that:
      i. The member cannot adequately participate in home, school, or community activities; and/ or the member presents a safety risk to self or others, and
      ii. Less intrusive and/or less intensive behavioral interventions have been tried and have not been successful and/or there is no equally effective alternative strategy available to address the member's behaviors

   c. Specific evaluations to determine developmental profile using **ONE or more of the following** standard tools:
      i. Adaptive/Functional skills: Vineland Adaptive Behavior Scales

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ii. Communication skills: Preschool Language Scale-5 (PLS-5), Clinical Evaluation of Language Fundamentals-5 (CELF-5), Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP)
iii. Cognitive Assessment (Wechsler scales, Kaufman scales)
iv. Social Skills Rating Scales (SSRS), Assessment of Basic Language and Learning Skills (ABLLS), Achenbach System of Empirically Based Assessment (ASEBA)
v. Behavior rating scales: ASEBA, Behavior Assessment System for Children, Third Ed. (BASC-3), Gilliam Autism Rating Scale

d. Expanded laboratory, documented routine developmental surveillance by providers at every well child visit, screening questionnaire, audiology assessment results, only if indicated.
e. There is evidence that the patient can participate in ABA therapy

3. A documented individualized treatment plan (ITP) that includes:
   a. A time-limited ITP that has been developed based on a diagnostic assessment within no more than 12 months of initiating treatment
   b. ITP is multidisciplinary in nature, member-centered, family-focused, community-based, culturally-competent and least intrusive
   c. Treatment plans that are templates or generic to a particular program are not acceptable ITP must address behaviors and symptoms that prevent the member from adequately participating in home, school, or community activities and/or present a safety risk to self or others, with a focus on parent training
   d. The ITP must address behaviors and symptoms that prevent the member from adequately participating in home, school, or community activities and/or present a safety risk to self or others, with a focus on parent training
   e. The ITP should take into account all school or other community resources available to the patient and provide evidence that the requested services are not redundant to other services already being provided. The ITP should include a review of a school-based IEP (if present) and how the ITP does not duplicate what is on the IEP. The ITP should also include a review of other treatment if present (e.g., outpatient mental health, speech therapy) and how the ITP does not duplicate these community-based resources. Coordination between the ABA provider and school and/or other service providers must take place directly between the providers, and not through parents.
   f. Coverage of ABA therapy in public or private schools is only provided under the following circumstances:
      i. Observation and assessment of behavior may take place in the school as part of the ITP assessment with the permission of school personnel
      ii. ABA may be provided on school property before and after regular school hours with the permission of school personnel
      iii. ABA may be provided during regular school hours with permission of school, when medically necessary, and the ABA intervention does not duplicate services the school could be expected to provide.
   g. ABA services do not eliminate the requirement that the school district is to provide appropriate mandatory educational services
   h. ABA services are not to be used for custodial caregiving services, including respite for caregivers

4. The ITP must include **All of the following**:
   a. The provider must use KP WA required report templates, available at Applied Behavioral Analysis Treatment for Autism | Kaiser Permanente Washington; updates will be posted on the provider site.
   b. Description of autistic behaviors that are targets for treatment. The targets for treatment should be based on where there is the most significant gap in functioning as measured by developmental and behavioral assessment including **TWO or more of the following:**

      i. ONE Norm-Referenced assessment is required to be completed during the initial ABA assessment, and to be readministered every 12 months. The provider is to use an instrument that will be suitable for serial measurements over time, and thus to measure functional progress over treatment periods. Some options for norm-based assessment are:
         - Vineland3 Adaptive Behavior Scales
         - Adaptive Behavior Assessment System (ABAS)
         - Pervasive Developmental Disorder Behavior Inventory (PDDBI)

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- Social Skills Improvement System (SSIS)

ii. ONE Criterion-Reference assessment is required to be completed during the initial ABA assessment, and to be updated every 6 months. Some options for this assessment are:

- The Carolina Curriculum
- Verbal Behavior Milestones Assessment and Placement Program (VB MAPP)
- Preschool Language Scale-5 (PLS-5),
- Promoting Emergence of Advanced Knowledge (PEAK)
- Accept-Identify-Move (AIM)
- Assessment of Basic Language and Learning Skills (ABBLS)
- Essentials for living (EFLs)
- The Assessment of Functional Living Skills (AFLS) or similar empirically based assessment tool.

c. A comprehensive description of treatment interventions and techniques specific to each of the targeted behavioral/symptoms
d. Establishment of baseline data, measurable treatment goals, and criteria for goal attainment and objective measures of progress for each intervention specified (including baseline and targeted goals)
e. Strategies for generalizing learning skills across persons and situations. Generalization plans are monitored closely as they are key to the patient transitioning to a lower level of care.
f. A description of parent education, including measurable parenting goals with baseline and criteria for goal attainment, and description of interventions. The parent goals are to include instruction in ABA principles in order to training and support generalization and maintenance of skills. Detailed description of interventions with parents to support their active participation in ABA treatment, including a plan for transferring interventions with the patient from the ABA provider to the parents. An ITP that does not adequately feature parental involvement may be subject to denial.
g. Strategies for communication and coordinating treatment with other providers and agencies including school-based special education programs, day care, and other health care providers.
h. Hours requested are itemized for each treatment modality (e.g., parent training, certified behavior technician time, lead behavior therapist, supervision, social skills group, completion of six-month progress report)
i. Measurable discharge criteria for completing treatment and plans for continued care after a discharge plan from ABA, which include **all of the following**:
    i. Plans for transition through a continuum of less intensive treatments such that patient's symptoms can be effectively managed at a lower level of care
    ii. Specific behavioral goals that, when reached, will indicate the patient is adequately participating in home, school, or community activities and/or is no longer presently a safety risk to self or others

5. Discharge Criteria - Typically individuals no longer need ABA services if **ONE of the following** is met:
    a. Patient behaviors and/or symptoms do not prevent them from adequately participating in home, school, or community activities and/or no longer present a safety risk to self or others
    b. Their behaviors and/or symptoms can be adequately addressed through alternative methods (i.e., school, developmental disability services, parent training)
    c. Functional and measurable progress toward treatment goals is not occurring as measured by (majority of goals are not being met, there is not significant progress on behaviors and/or symptoms that prevent them from adequately participating in home, school, or community activities, and/or no longer present a safety risk to self or others), improvement is not durable over time, and/or generalizable outside the treatment setting, and there is no reasonable expectation of further progress

6. Transition to a lower level of care. Discharge is often not a discrete event, but instead is a transitional process, to prevent relapse of skills. Transition to a lower level of care could include any of the following: lowered number of treatment hours (focused ABA), enhanced focus on training parents or other caregivers, or the use of other treatment modalities e.g., mental health counseling group treatments or other community support activities.

7. Coverage of development of the ITP does include time to do baseline assessments, review of past treatment (including IEPs) and development of a plan that includes parent training and coordination with other treatment

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providers. Six to 10 hours is usually sufficient for the development of the ITP. If additional time is being requested, clinical documentation to support medical necessity (e.g. more complex cases, or cases in which a complete functional analysis is needed) must be submitted.

8. The amount of treatment is based on medical necessity. As noted in the 2014 Agency for Healthcare Research and Quality update on A Review of Research of Therapies for Children with Autism Spectrum Disorder, early intervention programs (i.e., for children typically, under the age of six) are provided for up to 25 hours a week and can last as long as 12 weeks to 3 years. These services can include direct services to member/identified patient and/or parents by program manager/lead behavioral therapist and/or therapy assistants/behavioral technicians/paraprofessionals, supervision, and the development of a six-month progress report. In the unusual case of very acute and/or unsafe patient behavior, up to 40 hours/week of treatment may be authorized.

9. Fewer hours may be required (5-15 hours per week) for Focused ABA when the primary difficulty is in one targeted area (i.e., social skills deficits).

10. Caregiver coaching is considered best practice and needed for all ABA programs
    a. Caregiver coaching plans must include baseline behaviors, must have baselines measurable components, and mastery criteria
    b. Caregiver education must also include the teaching of ABA principles related to the patient goals (i.e., principles of reinforcement, behavior functions, schedules reinforcement, task analysis as a teaching strategy, etc.)
    c. Monthly meetings (in person or virtual) are required for generalization and maintenance of skills
    d. The initial caregiver coaching/education plan must be documented

11. Evaluation of progress: Every six months, the provider completes the KP ABA Progress Report. This document is used to review progress in treatment including the following information:
    a. How patient is progressing towards goals (i.e., what percentage of goals patient has achieved and how these goals have led to functional progress as it pertains to increasing patient's ability to adequately participate in home, school, or community activities, and/or decrease safety risk to self or others
    b. Progress towards parent goals (how parents have been active participants in the treatment, what percentage of parent goals have been passed, and progress towards transferring interventions with the patient to the parents.
    c. For goals that have not been met, describe reason for not meeting goals, how goals are being adjusted, and how interventions are being revised to meet goals.
    d. Any new goals that have been identified (if new goals are identified, include baseline and targeted performance). New goals should be geared towards progress or transition to less intensive interventions.
    e. A criterion referenced assessment is to be submitted every six months.
    f. How the patient is progressing towards discharge and/or plans for discharging from care and/or reducing intensity of intervention based on patient progress and/or the implementation of less intensive behavioral interventions. A discharge plan stating that ABA will be needed until he/she no longer meets criteria for ASD is not appropriate. A patient could still meet diagnostic criteria for ASD, but be able to be successfully and safely treated at a lower level of care.
    g. A brief description of what was done during the past six months to coordinate treatment with school and/or health care providers (i.e., phone call was made to speech therapist to make sure there is common picture communication system; a conference was held with the school to coordinate behavioral interventions for self-injurious behavior). This coordination must take place directly between the ABA provider and any other service providers, and not through the parents
    h. If functional progress is not occurring (i.e., one or two consecutive ITP's where patient is not meeting majority of goals and not making functional progress towards increased participation in home, school, or community activities and/or is not less of a safety risk to self or others) and there is not a reasonable expectation of further progress, then continuation of ABA services is not considered to be medically necessary

12. Every 12 months standardized (norm-referenced) developmental assessment should be re-administered to assess whether patient continues to be making functional and measurable progress. The provider is to use the same instrument over time as much as possible so scores can be compared over time to measure progress.

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13. The following are not considered to be medically necessary ABA services:
    a. More than one program manager/lead behavioral therapist for a member/identified patient at any one time.
    b. More than one agency/organization providing ABA services for a member/identified patient at any one time.
    c. If the school has determined that a child is eligible to receive services under an IEP which would overlap with ABA services and the school services are declined or discontinued by the parent.
    d. Activities and therapy modalities that do not constitute application of applied behavioral analysis techniques for treatment of autism. Examples include (but not limited to):
        i. Taking the member/identified patient to appointments or activities outside of the home (e.g., recreational activities, eating out, shopping, play activities, medical appointments), except when the member/identified patient has demonstrated a pattern of significant behavioral difficulties during such specific activities
        ii. Assisting the member/identified patient with academic work or functioning as a tutor, educational or other aide for the member/identified patient in school
        iii. Provision of services that are part of an IEP and therefore should be provided by school personnel, or other services that schools are obligated to provide
        iv. Doing housework or chores, or assisting the member/identified patient with housework or chores, except when the member has demonstrated a pattern of significant behavioral difficulties during specific housework or chores, or acquiring the skills to do specific housework or chores is part of the ABA treatment plan for the member/identified patient travel time residing in the member's home and functioning as live-in help (e.g., in an au-pair role)
14. All ABA visits with the patient and/or family should be documented. Documentation should include:
    a. Who was present at the visit?
    b. Duration of the visit
    c. What was the targeted behavior during the visit?
    d. What was the procedure/activity/intervention during visit?
    e. What was the response to procedure/activity/intervention?
    f. Intervention format (individual, group, supervision, parent training)
    g. Graphical or numerical data to track progress/participation
    h. Signature title, credentials of person completing documentation
    i. Include targeted behavior, interventions, response, modifications in techniques and plan for next visit with behavior tracking sheets that record and graph data collected for each visit

ABA Provider Qualifications and Procedure Codes

Providers delivering ABA must meet **ALL of the following** qualifications:

1. At a minimum, the lead behavioral therapist, providing treatment and clinical supervision of treatment program must demonstrate that she/he is a board-certified behavior analyst (BCBA).
2. ***Either***:
    A. Individually satisfy **ALL the following** requirements:
        i. Be a licensed health provider under Title 18, Revised Code of Washington, including but not limited to: speech therapist, occupational therapist, psychologist, pediatrician, neurologist, psychiatrist, mental health counselor, social worker; and
        ii. Be licensed to practice independently; and
        iii. Be credentialed and contracted by the Plan; ***or***
    B. Be employed by a Healthcare Delivery Organization that meets **All of the following** requirements:
        i. Be a hospital, mental health facility, home health agency or in-home agency licensed to provide home health services, or other mental health agency licensed by the Washington Department of Health; ***or*** a community mental health agency or home health agency licensed by the Washington Department of Social and Health Services; and
        ii. Be credentialed and contracted by the Plan.
        iii. Clinical supervision for unlicensed staff providing services must be provided by a lead behavioral therapist as indicated above. Must include, at a minimum bimonthly (once every 60 days) approval and review of the ITP and case review of every member receiving clinical health services; and

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iv. Must include, at a minimum, at least one hour of on-site supervision, with on-site observation for at least one hour for every 40 hours of service to the member.

CPT code	Description
97151	Behavior Identification Assessment, administered by QHP, each 15 minutes of QHP's time face-to-face with patient and/or guardian(s)/caregivers(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan
97152	Behavior Identification Supporting Assessment, administered by one technician under the direction of QHP, face-to-face with the patient, each 15 minutes
97153	Adaptive Behavior Treatment by Protocol, administered by technician under the direction of a QHP, face-to-face with one patient, each 15 minutes
97153 w/HO modifier	
97154	Group Adaptive Behavior Treatment by Protocol, administered by technician under direction of QHP, face-to-face with 2+ patients, each 15 minutes
97155	Adaptive Behavior Treatment with Protocol Modification, administered by QHP, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes
97156	Family Adaptive Behavior Treatment Guidance, administered by QHP (with or without patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes
97157	Multiple-Family Group Adaptive Behavior Treatment Guidance, administered by QHP (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes
97158	Group Adaptive Behavior Treatment with Protocol Modification, administered by QHP face-to-face with multiple patients, each 15 minutes

If requesting this service, please send the following documentation to support medical necessity:

- Last 6 months of clinical notes from requesting provider &/or specialist

The following information was used in the development of this document and is provided as background only. It is provided for historical purposes and does not necessarily reflect the most current published literature. When significant new articles are published that impact treatment option, Kaiser Permanente will review as needed. This information is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

Background

Autism is a neurodevelopmental disorder in the category of pervasive developmental disorders (PDD), which is a group of conditions that also include Rhett's disorder, childhood disintegrative disorder, Asperger's disorder, and pervasive developmental disorder not otherwise specified (PDD NOS). Autism is characterized by a triad of deficits involving impaired language development, reciprocal social interaction, and stereotyped repetitive patterns of behaviors and interests. The prevalence estimates released by the CDC based on 2002 data show that approximately one in fifty children in the US is autistic. These estimates indicate a dramatic increase in the recent years, which may be due to an actual increase in the occurrence of the disorder as well as the increased awareness of the disorder among the clinicians. There are no definitive medical tests to indicate the presence of any form of autism spectrum disorders (ASD). Diagnostic assessment includes use of ICD and DSM-IV diagnostic criteria and standardized methods to assess core and co-morbid conditions. Parents usually become aware of developmental problems in their child starting around the age of 18 months, but diagnosis is often not made until 2 years after the expression of parents' concerns. It may sometimes be delayed until close to the age of six (Ospina 2008, Granpeesheh 2009, Levy 2009, Spreckley 2009).

Autism is a lifelong condition with variable clinical course throughout childhood and adolescence. Many adults with autism may still require full-time care. While there is no known cure, the general agreement is that early diagnosis followed by appropriate treatment may improve outcomes in later years for most individuals. Over the past twenty years, a variety of therapies have been proposed to improve the symptoms associated with ASD, many of which have not been validated scientifically. These include pharmacological therapies, complementary therapies as diet modifications and vitamin therapy, speech and language therapy, and psychosocial treatments.

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The well-researched treatment programs are based on the principles of applied behavioral analysis (ABA), sometimes called behavioral therapy or behavioral modification. The approach has been outlined by Lovaas and colleagues in the 1980s and, as originally described, involves teaching appropriate behaviors by breaking tasks down into small discrete steps and training in a systematic and precise way called discrete trial training. It is delivered on a 1:1 basis, for 40 hours a week over a three-year period.

The approach of ABA is based on the concept that children with ASD have significant difficulties with learning, being unable to learn through imitation, and listening as normal children do. Its overall goal is to motivate the child to want to be successful. ABA is founded on behavioral principles of learning and motivation, consisting of reinforcement, extinction, stimulus control, and generalization. The basic learning principle at the core of ABA is the idea that the consequences of a behavior can either strengthen or weaken it; behavior that is followed by the presentation of desirable consequences will be strengthened (reinforcement), whereas behavior that is followed by aversive consequences or the removal of desirable consequences will be weakened.

A defining feature of ABA programs is that they are applied consistently. This is accomplished by the use of explicitly written programs for each skill to be taught or maladaptive behavior to be treated, and by having the behavioral analyst train everyone who works with the child to implement it. To increase the likelihood of the generalization of the treatment efforts, it is critical for the therapists and parents to be trained to implement the programs across situations, settings, and people. Typically, teaching trials are repeated until they are mastered. Maladaptive behaviors such as aggression and self-injury are not reinforced, whereas specific, appropriate alternative behaviors are either taught or maintained through positive reinforcement. Each child's program is unique to his/her needs that evolve with the child's progress. Accurate records are kept so that progress can be assessed, and programmatic changes made (Spreckley 2009, Granpeesheh 2009).

Treatment based on APA represents a wide range of early intervention strategies for children with autism. As indicated earlier, the first types of behavioral treatment programs developed, the discrete trial training, were very intensive and structured. Investigators found that children may have difficulty generalizing the information from these very structured sessions to group and community settings. One comprehensive intervention program reviewed by the National Research Council (NRC) was early intensive behavioral intervention (EIBI) based on the UCLA Young Autism Project Model. This is an intensive home-based program using the manual published by Lovaas and involves up to 40 hours of therapy per week for at least 2 years. Other EIBI programs were developed by other researchers (Howlin 2009, Reichow 2009).

Less structured more naturalistic behavior programs e.g. incidental teaching and pivot response training (PRT) have been developed but were not researched in a randomized controlled fashion. Currently, even structured sessions include naturalistic methods for increasing generalization and maintenance. Parent mediated interventions have been reported to be an important aspect of intervention. Overall, structured programs share a common core of set features including: 1. starting the intervention at the earliest possible age (3-4 years), 2. Intervention is intensive (20-40 hours per week), 3. Intervention is individualized, comprehensive, and targeting a wide range of skills, 4. Multiple behavior analytic procedures are used to develop adaptive repertoires, 5. Treatment is delivered in one-to-one format with gradual transition to group activities and natural contexts, 6. Treatment goals are guided by normal developmental sequence, and 7. Parents are, to different extents, trained and become active co-therapists (Levy 2009, Virues-Ortega 2010).

Medical Technology Assessment Committee (MTAC)

ABA Therapy

04/19/2010: MTAC REVIEW

Evidence Conclusion: There is lack of published well-conducted randomized controlled trials on behavioral interventions for young children with autism. The published trials had their limitations; they had small sample sizes, the majority were not randomized, the participants were frequently diagnosed without using standardized tools, the studies examined different treatments, with different delivery approaches and intensities, over different time spans (ranging from 12 weeks to 2 years) and had different measurement approaches for assessing outcomes. IQ was a major outcome for the majority of studies, and it might not be possible to determine whether an improved IQ results from true improvement of cognitive skills, or better test taking ability. In addition, IQ is not necessarily the main problem in autistic functioning. Autism treatment needs to address every developmental area, all areas of adaptive behavior, and then a whole set of aberrant behavioral responses, involving both positive and negative symptoms (Rogers 2008). A number of systematic reviews and meta-analyses of the

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published studies were conducted by several authors. The methodology of the analyses was valid in general, however even a well conducted meta-analysis is only as good as the studies it includes. The studies on intensive behavioral intervention, as indicated earlier, had their limitations and biases and varied widely in the treatments intensity, duration, mode of delivery, and outcome measures; all of which limits generalization of the pooled results. The meta-analyses either pooled the results of controlled studies only or all studies with or without comparison groups. Their results were conflicting, while, Virues-Ortega (2010), Eldevik (2009), Reichow (2009), Howlin (2009) and others show that that ABA /EIBI interventions were associated with improved outcome (primarily measured by IQ) among some children with autism, Ospina (2008) and Spreckley et al (2009) showed no statistically significant additional benefit of APA/EIBI intervention vs. other interventions applied to young children with ASD.
Dawson and colleagues' study (2010), a more recently published randomized controlled trial with valid methodology, can be considered the most rigorous RCT on comprehensive development behavioral intervention. The authors randomized 48 young children to receive Early Start Denver Model (ESDM), a comprehensive behavioral intervention, or to be referred to community providers for intervention commonly available in the community. They were followed up for 2 years and the primary outcome was change in Mullen Scales of Early learning (MSEL) and the Vineland Adaptive Behavior Scales (VABS) composite standard scores. The results of the trial suggest that very young children with autistic disorders may achieve higher cognitive and adaptive scores and improvement in diagnosis after a 2-year comprehensive intervention strategy that includes parental involvement. The study however does not allow determining if the benefits gained would be sustained over time. Conclusions: There is insufficient evidence from well-conducted large randomized comparative trials with long term follow-up to determine which comprehensive treatment approach is best for young children with autism, and in particular the most effective treatment for teaching specific skills given certain profiles and characteristics of the child.
Articles: The literature search revealed around 100 articles on ABA/ EIBI for young children with autism. The majority were reviews or articles not related to the current review. There were at least 6 systematic reviews with or without meta-analyses on ABA /EIBI intervention for young children with autism. A small more recent RCT (N=48) on the Early Start Denver Model for toddlers with autism was identified. The search also revealed a systematic review by Clinical Evidence on all interventions for autism including early multidisciplinary interventions based on APA and including home-based, school based, community based or multisite interventions.
Three of the meta-analyses on ABA/EIBI for young children were selected for critical appraisal as well as the recently published randomized trial. Dawson G, Rogers S, Munson J, et al. Randomized controlled trial of an intervention for toddlers with autism: The Early Start Denver Model, Pediatrics 2010;125:1:e17-e23 See Evidence Table Eldevik S, Hastings RP, Hughes JC, et al. Meta-analysis of early intensive behavioral intervention for children with autism J Clin Child Adolesc Psych 2008;38:439-450 See Evidence Table
Spreckley M, Boyd R. Efficacy of applied behavioral intervention in preschool children with autism for improving cognitive, language, and adaptive behavior: A systematic review and meta-analysis. J Pediatr 2009; 154:338-344. See Evidence Table Virues-Ortega J. Applied behavioral analytic intervention for autism in early childhood: Meta-analysis, meta-regression and dose-response meta-analysis of multiple outcomes. Clinical Psychology Review. 2010 , doi:10.1016/j.cpr.2010.01.008 See Evidence Table

The use of applied behavioral analysis therapy (ABA), early intensive behavior interventions (EIBI) for the treatment of young children with autism does not meet the *Kaiser Permanente Medical Technology Assessment Criteria.*

References

Dawson G, Rogers S, Munson J, Smith M, Winter J, Greenson J, Donaldson A, Varley J. Randomized, controlled trial of an intervention for toddlers with autism: the Early Start Denver Model. Pediatrics. 2010 Jan;125(1):e17-23. doi: 10.1542/peds.2009-0958. Epub 2009 Nov 30. PMID: 19948568; PMCID: PMC4951085.

Eldevik S, Hastings RP, Hughes JC, Jahr E, Eikeseth S, Cross S. Meta-analysis of Early Intensive Behavioral Intervention for children with autism. J Clin Child Adolesc Psychol. 2009 May;38(3):439-50. doi: 10.1080/15374410902851739. PMID: 19437303.

Spreckley M, Boyd R. Efficacy of applied behavioral intervention in preschool children with autism for improving cognitive, language, and adaptive behavior: a systematic review and meta-analysis. J Pediatr. 2009 Mar;154(3):338-44. doi: 10.1016/j.jpeds.2008.09.012. Epub 2008 Oct 31. PMID: 18950798.

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Virués-Ortega, Javier. Applied behavior analytic intervention for autism in early childhood: Meta-analysis, meta-regression and dose–response meta-analysis of multiple outcomes, Clinical Psychology Review, Volume 30, Issue 4, 2010, Pages 387-399, ISSN 0272-7358. Doi:10.1016/j.cpr.2010.01.008. https://www.sciencedirect.com/science/article/pii/S0272735810000218

Washington State Legislature. (2023, February 20). *How do I show that I have autism as an eligible condition?*. WAC 388-823-0500: https://apps.leg.wa.gov/wac/default.aspx?cite=388-823-0500

Applicable Codes

Providers must use the following codes to obtain reimbursement for ABA and ABA-related services

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT® Codes	Description
97151	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan
97152	Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes
97153 (with HO Modifier)	Adaptive behavior treatment by protocol, administered by physician or other qualified health professional, face-to-face with one patient.
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes

***Note:** Codes may not be all-inclusive. Deleted codes and codes not in effect at the time of service may not be covered.

****To verify authorization requirements for a specific code by plan type, please use the **Pre-authorization Code Check**.

Creation Date	Review Date	Date Last Revised
05/07/2010	05/04/2010 MDCRPC, 05/03/2011 MDCRPC, 04/03/2012 MDCRPC, 12/04/2012 MDCRPC ,10/03/2013 MPC ,12/03/2013 MPC, 08/05/2014 MPC, 11/04/2014MPC, 04/07/2015MPC,	10/01/2024

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	02/02/2016[MPC], 12/06/2016[MPC], 10/03/2017[MPC], 08/07/2018[MPC], 08/06/2019[MPC], 08/04/2020[MPC], 08/03/2021[MPC], 08/02/2022[MPC], 08/01/2023[MPC], 11/05/2024[MPC]	

[MDCRPC] Medical Director Clinical Review and Policy Committee

[MPC] Medical Policy Committee

Revision History	Description
02/07/2017	Revised ABA criteria for commercial members
12/05/2017	MPC approved to delete indication related to school coverage for ABA Therapy (commercial members, except MS)
01/09/2018	MPC approved to modify criteria to remove any language regarding school practices
11/01/2018	Removed the H codes and added the ABA Reimbursable Services
08/06/2019	Revised ABA criteria for commercial members and updated background information to highlight ITP updates
07/06/2021	MPC approved to adopt updates to clinical criteria for Non-Medicare members, with the exception of Microsoft, as there is separately maintained criteria for Microsoft members. Revisions made to clarify requirements, and a new requirement was added for two or more developmental and behavioral assessments used to measure gaps in functioning instead of one. Updated applicable coding to exclude H2017, 0362T, and 0373T. Requires 60-day notice, effective date 10/01/2021.
08/03/2021	Format change: merged separate non-Medicare criteria into main page (Microsoft criteria still a separate document)
01/03/2022	Updated Microsoft SPD language from 2022 document - replaced the terms child or dependent with ‘member’ throughout.
10/04/2022	MPC approved to modify ABA criteria to clarify coverage language.
11/07/2023	MPC approved to edit language in the current policy to reference WAC 388-823-0500 and align clinical criteria language of provider types with the WAC. MPC should remove lack of parental involvement with ABA treatment from discharge criteria but maintain parent/guardian coaching plan as an integral component of ABA treatment plan requirements.
10/01/2024	MPC approved the criteria updates to the Applied Behavioral Analysis Therapy (ABA) policy to add clarifying language on coverage.60-day notice required. Effective March 1st, 2024.

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