Clinical Policy: Applied Behavior Analysis (Medi-Cal)

Reference Number: CA.CP.BH.104 Coding Implications
Date of Last Revision: 01/26 Revision Log

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

Description

This clinical policy outlines the medical necessity criteria for Applied Behavior Analysis (ABA) treatment services within California Health Net, both as a preventive service and pursuant to the federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit as outlined in All Plan Letter (APL) 23-005 or any superseding APL. The criteria are established in accordance with APL 23-010, or any superseding APLs, as well as applicable mental health parity requirements.

Under the EPSDT benefit, states are required to provide any Medicaid-covered service listed within the mandatory and optional service categories in Section 1905(a) of the Social Security Act. This requirement applies regardless of whether the service is included in California's Medicaid State Plan.[1]

Behavior Health Treatment (BHT) services include applied behavioral analysis (ABA) and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction. The goal is to promote, to the maximum extent practicable, the functioning of a beneficiary, including those with or without a diagnosis of ASD.[2]

BHT services are medically necessary if they correct or ameliorate defects and physical and mental illnesses and conditions discovered through screening.[2]

***Note**: For reference within this policy Behavior Health Treatment (BHT) services consist of Applied Behavior Analysis.*

Policy/Criteria

I. It is the policy of Health Net that when a covered benefit, Applied Behavior Analysis (ABA) services are **medically necessary** when meeting all the following:

A. Member/enrollee is < 21 years old and medically stable;
B. Member/enrollee does not have a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities;
C. A licensed physician or licensed clinical psychologist recommends BHT services for the treatment of ASD as medically necessary, regardless of diagnosis;
Note:
- *Submission of Health Net's Applied Behavior Analysis (ABA) recommendation/referral form signed by a physician (MD/DO) or licensed clinical psychologist (PsyD/PhD) is encouraged to meet this requirement.*
- *For member/enrollees who have no diagnosis or a diagnosis other than autism, the recommendation/referral form must be less than one year old;*

D. All treatment plan documents (treatment plan, goals, and behavior intervention plan, if submitted separately) include both of the following:
   1. Heath Insurance Portability and Accountability Act- (HIPAA) compliant signature, credentials, and role of the qualified autism provider, professional or paraprofessional responsible for the member/enrollee's care;
   2. Name of the member/enrollee's parent or legal guardian, and any additional person who reviewed and signed the plan;
      ***Note**: Parent/legal guardian signature is preferred but not required.*
E. Service request is for one of the following:
   1. Behavioral assessment;
   2. Initiation of ABA treatment, includes all of the following:
      a. Behavioral assessment, completed no more than two months prior to the start of the initial treatment authorization, by the current rendering provider, includes all the following:
         i. Completed by a provider (e.g., PhD, MD, BCBA, LMFT, etc.) with relevant experience/training in the design and implementation of behavioral modification systems;
         ii. Record review;
         iii. Interviews;
         iv. Rating scales;
         v. Direct observation and measurement of behavior using one of the following procedures:
            a) Continuous procedures (records every occurrence and/or duration of a target behavior during each of a series of designated observation periods);
            b) Discontinuous procedures (divides each designated observation period into a series of brief intervals);
         vi. Results from at least one of the following types of assessments (to include visual representations [graphs, tables, grids] as appropriate), depending on the member/enrollee's noted areas of need:
            a) Maladaptive behavior assessments for members/enrollees who exhibit problem behaviors that are disruptive and/or dangerous, including but not limited to, one of following functional behavioral assessments (FBA):
               i) Descriptive FBA (rating scales, direct observation, data review);
               ii) Traditional functional analyses;
               iii) Interview-Informed, Synthesized Contingency Analysis (IISCA);
            b) Skills acquisition assessments, for members/enrollees who demonstrate the need for skill acquisition, including but not limited to one of the following:
               i) Verbal Behavior Milestones and Assessment Placement Program (VB-MAPP);
               ii) Assessment of Basic Language and Learning Skills-Revised (ABLLSR);
               iii) Assessment of Functional Living Skills (AFLS);
               iv) Promoting the Emergence of Advanced Knowledge Generalization (PEAK) Skills Assessment;
               v) Essentials for Living (EFL);

vi) Social Skills Improvement System (SSIS);
vii) Socially Savvy;
viii) Other valid forms of evidence-based skills assessment tools;
***Note**: If the Vineland Adaptive Behavior Scales or Adaptive Behavior Assessment System (ABAS) is used as a skills assessment, an additional, direct skills assessment is required from the list above.*

b. A diagnostic interview/evaluation has been conducted within 12 months of the authorization request and meets all of the following:
i.) Reason member/enrollee is seeking services;
ii.) Comprehensive mental status exam that supports the treatment;
iii.) DSM diagnosis (current version), including recommendations for active treatment interventions;
iv.) History & symptomology consistent with DSM (current version) criteria;
v.) Psychiatric treatment history;
vi.) Assessment of current and past suicide/homicide danger;
vii.) Level of familial support assessed and involved as indicated;
viii.) Identified areas for improvement;
ix.) Assessment of strengths, skills, abilities, motivation;
x.) Medical history;
xi.) All current medications with dosages;

c. Individualized treatment plan aligns with the behavior assessment, is valid for six months from the date the initial plan is written, and includes all the following:
i. Descriptive information to include a brief background and medical history;
ii. Clinical interview that includes explicit parent/caregiver concerns;
iii. Individualized goals with measurable, targeted outcomes and timelines, including transition/discharge planning, including all the following:
iv. Identified in collaboration with the member/enrollee, family members, and community providers;
v. Skill acquisition goals including baseline data and mastery criteria;
vi. Behavior reduction goals including baseline data, operational definition/topography of behavior, treatment strategies and graphs;
vii. Intervention focused on active core symptoms and emphasizing generalization and maintenance of skills in areas of need, including interventions related to development of spontaneous social communication, adaptive skills, and appropriate behaviors, tailored to the member/enrollee;
viii. A dedicated crisis plan;
ix. Detailed school-based plan requirements, as applicable, include all the following:
***Note**: Managed care plans (MCP) are the primary provider of medically necessary services and are responsible for providing medically necessary BHT services that have been discontinued by the Local Educational Agency (LEA).*
a) Summary of the clinical rationale for providing ABA services in the school setting, including the treatment start date;
b) Documentation of planned treatment hours, schedule and setting proportional to the level of need;

c) Target behaviors that are operationally defined with measurable data regarding the frequency, symptom intensity, duration, or other objective measures of baseline and current levels;
d) Days and times when problem behaviors occur at a high frequency, intensity, and/or duration;
e) For member/enrollees with an Individualized Educational Plan (IEP), documentation must describe the services included and provide clinical justification for why school-based interventions are insufficient to meet the member/enrollee's presenting needs in the school setting, resulting in the need for ABA provider support;
***Note**: BHT Services included in the IEP must not be reduced or discontinued without formal amendment of the IEP.*
f) Outline of goals related to behavior reduction and skill acquisition that represent desirable behaviors and achieve the same outcome or meet the same need as a less desirable problem behavior;
g) Titration plan outlines when school services can be reduced or stopped, based on a timeline with clear progress criteria;
h) Behavior reduction graphs tailored for the school setting;
***Note**: The most recent school-based educational support plan may be shared as supporting documentation for members/enrollees who attend school;*
i) Detailed coordination of care plan to support transfer of instructional strategies and interventions to school staff;

x. Treatment setting with rationale for how the setting will maximize treatment outcomes, considering the assessed needs, strengths, and available resources (i.e., home, school (onsite or remote), or community-based settings);
xi. Number of treatment hours, meets all the following:
a) Justified by level of impairment, severity of symptoms, domains requiring treatment, length of treatment history, and response to intervention;
b) Considers member/enrollee's age, school attendance requirements, and other daily activities;
***Note**: The number of medically necessary BHT hours may not be reduced based on time spent in school or participating in other activities.*
c) Incorporates supervision and caregiver training;
***Note**: Parent/guardian participation is not required.*
d) Outlines hours of therapy per day with the goal of increasing or decreasing the intensity of therapy as the member/enrollee's ability to tolerate and participate permits, documents all of the following:
***Note**: The number of treatment hours must not be reduced based on time spent in school or participating in other activities.*
i) Treatment hours provided to the member/enrollee meet one of the following:
1) Do not exceed six hours per day up to a total of 30 hours per week;
2) Clinical documentation justifies additional hours beyond six hours per day or a total of 30 hours per week (i.e. member/enrollee

exhibits high intensity, high frequency behaviors, and/or significant skill deficits);

ii) Treatment takes into consideration the developmental level of each member/enrollee, and treatment schedules support their needs, including rest and nutrition breaks, as well as opportunities for peer interaction;

xii. Documentation that ABA treatment will be delivered by one of the following ABA-credentialed professionals and is consistent with ABA techniques:
   a) Board Certified Behavior Analyst (Qualified Autism Service (QAS) provider);
   b) Qualified Autism Service (QAS) professional meeting all the following:
      i.) Supervised by a QAS provider;
      ii.) Provides treatment pursuant to a treatment plan developed and approved by the QAS Provider;
      iii.) Is one of the following:
         1) Associate Behavioral Analysts;
         2) Behavior Management Assistants;
         3) Psychological Associates under the supervision of a licensed behavioral health provider;
         4) Associate Marriage and Family Therapists under the supervision of a licensed behavioral health provider;
         5) Associate Clinical Social Workers under the supervision of a licensed behavioral health practitioner;
         6) Associate Professional Clinical Counselors supervision of a licensed behavioral health provider;
   c) Qualified Autism Service paraprofessional (unlicensed and uncertified individuals) meeting all the following:
      i.) Supervised by a QAS Provider or QAS Professional;
      ii.) Provides treatment and implements services pursuant to a treatment plan developed and approved by the QAS Provider;

xiii. Adaptive Behavior Treatment with Protocol Modification occurs for at least two hours per week or 10% of the direct service hours provided, whichever is greater;
   Note: *One to two hours per week for less than 10 hours per week is acceptable;*

xiv. Coordination of care includes all the following:
   a) Identifies each alternative provider who is responsible for delivering services;
   b) Documentation of dates and outcomes from coordination of care efforts;
   c) Services provided during school hours must include effective coordination with the Local Education Agencies (LEA);

xv. Parent/Caregiver training that is performance based and caregiver-driven, including all the following:
   Note*: Parent/caregiver participation is encouraged but not required.*
   a) Goals for family involvement within the treatment plan including baseline data and mastery criteria;

b) A documented plan for parent/caregiver training, ideally for a minimum of two hours per month, with clinical documentation justifying the need for fewer hours;
c) An assessment for barriers to family engagement, and documented plan for addressing barriers;

xvi. Transition planning, including discharge considerations made with input from the entire care team (to include the parent/guardian), involving a gradual step-down in services and a documented titration plan includes all the following:
Note: *Only the determination that services are no longer medically necessary under the EPSDT standard can be used to reduce or eliminate services. Parent/guardian participation is encouraged but not required.*
a) Specific titration goals and plan indicating how service hours will be titrated;
b) Individualized, realistic/attainable and specific goals for discharge and/or transfer to alternative or less intensive levels of care;
c) Recommended services member/enrollee can access upon discharge;
d) Exit plan;

3. Continuation of ABA treatment, meets all the following:
   a. Member/enrollee's behavior concerns are not exacerbated by treatment;
   b. Member/enrollee has the cognitive ability to retain and generalize advancement in treatment goals;
   c. There is reasonable expectation that the member/enrollee will benefit from the continuation of ABA services to ameliorate or maintain the member/enrollee's condition to prevent worsening or the development of additional problems;
   d. Updated behavior assessment is completed at least every six months (or as clinically appropriate, or as state mandated) and meets criteria in I.E.2.a.:
   e. Documentation of percentage of scheduled sessions successfully completed for the member/enrollee and caregiver participation;
   Note*: If attendance falls below 80% of the authorized hours within an authorization period, as specified in the individualized treatment plan and caregiver training plan, supporting documentation is required to justify continuation of ABA services at the previously approved level. When absences are attributed to medical, educational, or family barriers, documentation must also demonstrate the actions taken to address such barriers.*
   f. Parent/Caregiver training that is performance-based and caregiver-driven, including all the following:
   Note: Parent/caregiver participation is encouraged but not required.
      i. Goals for family involvement within the treatment plan including baseline data and mastery criteria;
      ii. Documented family participation in treatment, or attempts to engage caregivers;
      iii. An assessment for barriers to family engagement, and documented plan for addressing barriers;
   g. Documented coordination of care and communication regarding additional provider responsibilities, meets all the following:

***Note**: Medically necessary BHT services are not considered duplicative when there is overlapping responsibility with another entity for providing BHT services, unless the other entity is currently delivering the same type of service (e.g., ABA), addressing the same deficits, and targeting equivalent goals.*

i. Individualized expectations, prescribed services, service frequency, scope and duration, and goals to be achieved;
ii. Progress related to treatment/services provided;
iii. Medical needs of the member/enrollee for BHT services are assessed across community settings and delivered in a timely manner;
iv. Coordination of the provision of all services, including durable medical equipment and medication, to prevent duplicative services;
v. Documentation of coordination attempts if unsuccessful;
vi. Documentation indicates that the member/enrollee's medical needs for BHT services are being met in a timely manner, regardless of payer, and based on the individual needs;

h. An updated treatment plan is reviewed, revised, or modified, no less than every six months, and documents all of the following:
i. Member/enrollees may have continued access to out-of-network providers (continuity of care) for up to 12 months;
ii. One of the following:
a) Criteria noted in I.E.2.c. continues to be met to sustain or support the member/enrollee's health condition, prevent the condition from worsening, or prevent the development of additional problems;
b) Services are no longer medically necessary under the EPSDT standard and treatment can be modified or discontinued;
iii. Supplementary BHT services, as applicable, coordinated with a Local Educational Agency (LEA), provided to address any of the following:
a) Gaps in service caused when a LEA discontinues the provision of BHT services;
b) Medically necessary services that are still needed but are not documented in an IEP or IFSP/IHSP. Services may be coordinated in a school-linked setting;
iv. Transition planning meets all of the following:
a) Transition planning and discharge considerations are made with input from the entire care team, to include the parent/guardian and involving a gradual step-down in services;
***Note:** Parent/caregiver participation is encouraged but not required.*
b) Documented titration plan includes the following:
i.) Specific titration goals and plan indicating how service hours will be titrated;
ii.) Individualized, realistic/attainable and specific goals for discharge and/or transfer to alternative or less intensive levels of care;

iii.) Updated progress towards goals achieved over the prior authorization period;
iv.) Recommended services member/enrollee can access upon discharge;

v. Documented progress toward goals since the last authorization includes all of the following:
   a) Updated data collected during previous treatment authorization, corresponding to all treatment settings, including but not limited to, home, school, clinic, community setting, etc.;
   b) Progress with behavior reduction, as applicable, noted in a clear and legible graphic display, includes all of the following:
      i.) Clear labels on each axis with indicators of treatment changes and Environmental variables that could effect change,
      ii.) Baseline data,
      iii.) Behavior reduction progress over time,
      iv.) Frequency and/or duration of behaviors;
   c) Progress with skill acquisition goals including baseline data and updated progress data for each treatment goal;

vi. If limited progress, both of the following are documented:
   ***Note**: Limited progress is defined as minimal to no improvement toward: mastery of treatment goals, improvement in meaningful skills of independence and self-care, improved scores on direct skills assessments and/or minimal reduction in behaviors targeted for reduction.*
   a) Updated assessment identifies determining factors that may be contributing to inadequate progress; however, services are still needed to ameliorate or maintain the member/enrollee's condition;
   b) Changes to the treatment plan from the prior authorization period may include the following, as applicable:
      i.) Modification of treatment plan goals and intervention strategies;
      ii.) Increased time and/or frequency working on targets;
      iii.) Increased parent/caregiver training and supervision;
      iv.) Increased staff supervision and training;
      v.) Identification and resolution of barriers to treatment implementation;
      vi.) Newly identified co-existing conditions, as applicable;
      vii.) Consideration of alternative treatment settings;
      viii.) Consideration of the effectiveness of ABA;
      ix.) Evaluation for other services that may be helpful for added support including but not limited to, speech therapy, occupational therapy, psychiatric evaluation, psychotherapy, case management, family therapy, feeding therapy, and school-based supports.

II. It is the policy of Health Net that when a covered benefit, Applied Behavior Analysis (ABA)/BHT services may be appropriate for **discontinuation and/or transfer to alternative or less intensive levels of care** only when a determination that services are no longer medically necessary under the Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) standard is made based on the following:
A. Member/enrollee has achieved the desired, socially significant outcomes and

treatment is not required to maintain functioning or prevent regression;

B. Services are in lieu of school (member/enrollees age six or older), respite care, or other community-based settings of care;
C. There has been no clinically significant progress or measurable improvement towards treatment plan goals for a period of at least six months, and there is not a reasonable expectation that a revised treatment plan could lead to clinically significant progress, such as, but not limited to, the following:
   1. A consistent lack of change in behavior reduction and skill acquisition data;
   2. An increase in behaviors targeted for reduction;
   3. Failure to meet predefined mastery criteria for a specified duration;
   4. ABA treatment plan gains are not generalizable or durable over time and do not transfer to the larger community setting after successive progress review periods and repeated modifications to the treatment plan;
D. Treatment or intensity of treatment is being provided for the convenience or preference of the member/enrollee, parent/guardian, or other non-ABA service providers (school or other alternative providers);
E. The decision is made by the adult member/enrollee (who holds their own medical rights), family, or the behavior analyst to end or temporarily suspend services due to, but not limited to, any of the following:
   1. The parent/caregiver can continue the behavior interventions independently;
   2. The parent/caregiver wants to discontinue services and withdraws consent for treatment;
   3. The parent/caregiver and provider are unable to reconcile essential issues in treatment planning and delivery;
   4. The parent/caregiver's circumstances or interest in treatment change;
      Note: *BHT services cannot be denied or discontinued solely due to a lack of parent/caregiver training or participation.*
F. The member/enrollee has transitioned to another provider or community resources for alternative treatment.

III. It is the policy of Health Net that Applied Behavior Analysis (ABA)/ Behavior Health Treatment (BHT) services are **not medically necessary** for any of the following:
A. Services rendered when continued clinical benefit is not expected, unless the services are determined to be medically necessary;
B. Provision or coordination of respite, day care, recreational services, educational services;
C. Reimbursement of a parent, legal guardian, or legally responsible person for costs associated with participation under the behavioral treatment plan;
D. Treatment where the sole purpose is vocationally or recreationally-based;
E. Custodial care, including any of the following;
   1. Provided primarily to maintain the member/enrollee's or anyone else's safety;
   2. Provided by persons without professional skills or training;
F. Services, supplies, or procedures performed in a non-conventional setting (i.e., resorts, spas);
G. Services rendered by a parent or legal custodian;
H. Services that are not evidence-based behavioral intervention practices.

Background
Applied Behavior Analysis (ABA) is the application of behavioral principles to everyday situations, intended to increase skills or decrease targeted behaviors. ABA has been used to improve areas such as language, self-help, and play skills, as well as decrease behaviors such as aggression, self-stimulatory behaviors, and self-injury. Treatment may vary in terms of intensity and duration, complexity, and treatment goals. The extent of treatment provided can be characterized as focused or comprehensive.[3]

California Department of Health Care Services, Managed All Plan Letters
APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

APL 23-010 (Revised)[2]
On July 7, 2014, the Centers for Medicare and Medicaid Services (CMS) released guidance on coverage of BHT services pursuant to federal law which requires the EPSDT benefit to include a comprehensive array of preventive, diagnostic, and treatment services for low-income individuals under 21 years of age, which encompasses BHT services.

APL 23-005[1]
Under the benefit of EPSDT, states are required to provide any Medicaid-covered service listed within the categories of mandatory and optional services in the SSA Section 1905(a), regardless of whether such services are covered under California's Medicaid State Plan, for members who are eligible for EPSDT services when the services are determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions

For additional information on EPSDT requirements, including the definition of "Medically Necessary," see APL 23-005: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21, or any superseding APL.

Additional information on mental health parity, see APL 22-006: Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services, or any superseding APL. California's Medicaid State Plan is available at: https://www.dhcs.ca.gov/formsandpubs/laws/Pages/californistateplan.aspx.

Council of Autism Service providers (CASP)[4]
The Council of Autism Service Providers (CASP) has developed guidelines and recommendations that reflect established research findings and best clinical practices. There are five core characteristics of applied behavior analysis (ABA) that should be present throughout all phases of assessment and treatment in the form of essential practice elements as follows:
Core characteristics of ABA treatment:

1. An objective assessment and analysis of the person's condition by observing how the environment affects their behavior, as evidenced through appropriate measurement.
2. Understanding the context of the behavior and the behavior's value to the person, their caregivers, their family, and the community.

3. Promotion of the person's dignity
4. Utilization of the principles and procedures of behavior analysis to improve the person's health, skills, independence, quality of life and autonomy.
5. Consistent, ongoing, objective data analysis to inform clinical decision making.

Essential practice elements:

1. A comprehensive assessment that describes specific levels of behavior(s) at baseline and informs the subsequent establishment of meaningful treatment goals.
2. An emphasis on understanding the current and future value or social importance of behavior(s) targeted for treatment.
3. Reasonable efforts toward collaboration with the person receiving treatment, their guardians if applicable, and those who support them (e.g., caregivers, care team) in developing meaningful treatment goals.
4. A practical focus on establishing small units of behavior that build toward larger, more significant changes in abilities related to improved health, safety, skill acquisition, and/or levels of independence and autonomy.
5. Collection, quantification, and analysis of direct observational data on behavioral targets during treatment and follow-up to maximize and maintain progress toward treatment goals.
6. Design and management of social and learning environment(s) to minimize challenging behavior(s) and maximize the rate of progress toward all goals.
7. An approach to the treatment of challenging behavior that links the function(s) of, or the reason(s) for, the behavior with programmed intervention strategies.
8. Use of a carefully constructed, individualized, and detailed behavior-analytic treatment plan that utilizes reinforcement and other behavioral principles and excludes methods or techniques not based on established behavioral principles and theory.
9. Use of treatment protocols that are implemented repeatedly, frequently, and consistently across environments until discharge criteria are met.
10. An emphasis on frequent, ongoing analysis and adjustments to the treatment plan based on patient progress.
11. Direct training of caregivers and other involved laypersons and professionals, as appropriate, to support increased abilities and generalization and maintenance of behavioral improvements.
12. A comprehensive infrastructure for case supervision by a behavior analyst of all assessments and treatment.

Council of Autism Service Providers (CASP) Practice Parameters for Telehealth-Implementation of Applied Behavior Analysis[5]

Due to a shortage of providers and disparities which exist in behavioral health care access, telehealth services have become a viable solution to address health access to treat members/enrollees with ASD. This service is not intended to replace in person service, as it is intended to supplement the traditional in person service delivery model.[4]" Clinical decisions on telehealth service delivery models should be selected based on the individual needs, strengths, preference of service modality, caregiver availability and environmental support available. Providers should refer to respective state allowances for telehealth services and reference the most updated CASP Practice Parameters for Telehealth-Implementation of Applied Behavior Analysis.

American Academy of Pediatrics (AAP)[6]
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 behavioral characteristics that present differently depending on age, language level, and cognitive abilities. Core symptoms cluster in 2 domains (social communication, interaction, and restricted, repetitive patterns of behavior), as described in the DSM-5TR.

The Diagnostic and Statistical Manual of Mental Disorder, Fifth edition (DSM-5-TR)[7]
The Diagnostic and Statistical Manual of Mental Disorder lists 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 3 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 can speak in full sentences and engages in communication but who is to and from conversation with others fails, and who attempts to make friends are odd and typically unsuccessful.	Inflexibility of behavior cases significant interference with functioning in one or more context. Difficulty switching between activities. Problems of organization and planning hamper independence.

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted

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 one 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
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
0362T	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior
0373T	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following

CPT®* Codes	Description
	components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits. destructive behavior; completion in an environment that is customized to the patient's behavior
99366	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional
99368	Medical team conference with interdisciplinary team of health care professionals, patient, and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional

HCPCS®* Codes	Description
H0031	Mental health assessment, by nonphysician
H0032	Mental health service plan development by nonphysician
H0046	Mental health services, not otherwise specified
H2012	Behavioral health day treatment, per hour
H2014	Skills training and development, per 15 minutes
H2019	Therapeutic behavioral services, per 15 minutes
S5110	Home care training, family; per 15 minutes
S5111	Home care training, family; per session

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy created.	01/26	01/26

References

1. California Department of Healthcare Services. All Plan Letter. APL 23-005: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21. https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx. Revised March 16, 2023. Accessed December 31, 2025.
2. California Department of Healthcare Services. All Plan Letter. APL 23-010: Responsibilities for behavioral health treatment coverage for members under the age of 21. https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx. Published November 22, 2023. Accessed December 31, 2025.
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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. This clinical policy is not intended to recommend treatment for members. Members 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, 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 and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, 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, 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.