Georgia Medicaid UM Guideline

Subject: Adaptive Behavioral Treatment for Autism Spectrum Disorder
Guideline #: CG-BEH-02
Status: Reviewed

Current Effective Date: 9/27/2017

Last Review Date: 8/3/2017

Description

IMPORTANT INFORMATION ABOUT THIS GUIDELINE:

This guideline is to be applied to the extent there is a state mandate or specific benefit coverage for an Adaptive Behavioral Treatment (ABT) such as Intensive Behavioral Intervention (IBI) or Applied Behavioral Analysis (ABA) for Autism Spectrum Disorder (ASD).

This document addresses the treatment of ASDs and other Pervasive developmental disorders (PDDs) with behavioral interventions such as ABA when a state requires or benefit language explicitly provides coverage for the behavioral intervention(s).In this document, the term 'ABT', which includes services such as ABA and IBI, refers to services that may be provided as part of ABA and IBI.

The diagnosis of ASD can be complex and difficult due to the diversity of the presentation of symptoms and their severity. Due to the multitude of possible causes and potential confusion with other conditions, many tests exist to diagnose ASD that may or may not be appropriate. It is vital that parents or guardians of children suspected of having an ASD seek early diagnosis and care for the child to increase any potential benefits of treatment. The recommendations for evaluation and assessment of ASD as published by the American Academy of Pediatrics (Zwaigenbaum, 2015b), and the American Academy of Child and Adolescent Psychiatry (Volkmar, 2014) are resources that can be utilized.

ASD, as defined in the fifth edition of the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), includes disorders previously referred to as:

- Atypical autism
- Asperger's disorder
- Childhood autism
- Childhood disintegrative disorder
- Early infantile autism
- High-functioning autism
- Kanner's autism
- PDD not otherwise specified

Note: Benefits, state mandates and regulatory requirements should be verified prior to application of criteria listed below.

Note: For information regarding testing or treatment of ASD and other related conditions, please see:

- BEH.00004 Activity Therapy for Autism Spectrum Disorders and Rett Syndrome
- CG-BEH-01 Screening and Assessment for Autism Spectrum Disorders and Rett Syndrome
- CG-BEH-10 Basic Skills Training/Social Skills Training
- GENE.00021 Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability (Intellectual Developmental Disorder) and Congenital Anomalies
- MED.00107 Medical and Other Non-Behavioral Health Related Treatments for Autism Spectrum Disorders and Rett Syndrome

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Clinical Indications

I. Assessment and Planning

The assessment and planning for an initial course of behavioral intervention services may be **covered for an** individual with ASD **when** a state mandate requires or a benefit plan explicitly provides coverage for ABT and **ALL** of the following **selection criteria** are met:

A. A diagnosis of ASD has been made by a licensed medical professional or other qualified health care professional as is consistent with state licensing requirements; **and**
B. Documentation is provided which describes the *person-centered treatment plan* that includes all of the following:
    1. Addresses the identified behavioral, psychological, family, and medical concerns; **and**
    2. Has measurable goals in objective and measurable terms based on standardized assessments that address the behaviors and impairments for which the intervention is to be applied (**Note:** this should include, for each goal, baseline measurements, progress to date and anticipated timeline for achievement based on both the initial assessment and subsequent interim assessments over the duration of the intervention); **and**
    3. Documents that ABT services will be delivered by an appropriate provider who is licensed or certified according to applicable state laws and benefit plan requirements; **and**
C. Assessments of motor, language, social, and adaptive functions have been completed; **and**
D. The *person-centered ABT treatment plan* incorporates goals appropriate for the individual's age and impairments including social, communication, language skills or adaptive functioning that have been identified as deficient relative to age expected norms with these elements for each target:
    1. Anticipated timeline for achievement of the goal(s), based on both the initial assessment and subsequent interim assessments over the duration of the intervention; **and**
    2. Family education and training interventions including the behavior parents/caregivers are expected to demonstrate; **and**
    3. Estimated date of mastery; **and**
    4. Plan for generalization; **and**
    5. Discharge or transition planning.
E. The following must be ruled out as causal reasons for behavior: Primary hearing deficits, primary speech disorder, and heavy metal poisoning. (State of Georgia Medicaid)

One or more of the following ABT behavioral assessments may be covered when any of the criteria above have been met and the specific criteria for each type of assessment below have been met:

A. *Behavior identification assessment:* Required prior to beginning a course of ABT. Each request for ABT must include an assessment involving the use of a standardized assessment (for example, Verbal Behavior Milestones Assessment and Placement Program [VB-MAPP], the Vineland Adaptive Behavior Scale [Vineland], etc.).
B. *Observational behavioral assessment:* May be necessary when one or more non-redirectable disruptive behaviors are present. A request for an *observational behavioral assessment* must provide a description of the disruptive behavior(s) identified. Examples of such behaviors are repetitive gestures or vocalizations, pica, elopement, etc. that are not manageable through redirection techniques. The conduction of the *behavior identification assessment and observational behavioral assessment* together should comprise up to 20 hours evaluation time. If more than 20 hours *behavior identification assessment and observational behavioral assessment* together are requested, a rationale must be provided with the request describing the specific situation that warrants additional assessment time.

Note: Repeat *behavior identification assessment and observational behavioral assessment* may be needed every 6 months when indicated by periodic measurements using standardized assessments. Such repeat assessment should be comprised of fewer than 20 hours and result in an updated treatment and progress report.

C. *Exposure behavioral assessment:* May be necessary when one or more non-redirectable disruptive behaviors that pose significant risk of harm to the individual or others are present, and an appropriate intervention has been chosen and planned. A request for an *exposure behavioral assessment* must include the following:
    1. Description of the behavior(s) that pose significant risk of harm to the individual or others; **and**
    2. Description of how the plan is to expose the individual to social or environment stimuli associated with the disruptive behavior; **and**
    3. Description of how the assessment will be conducted in a setting conducive to the safety of the individual and other individuals who may be present, including but not limited to, physician, other qualified health care professional, or technician.

II. Adaptive Behavioral Treatment (ABT)

Adaptive behavior treatment may be **covered** for an individual with ASD when a state mandate requires or a benefit plan explicitly provides coverage for ABT and **ALL** of the following selection criteria have been met:

A. The individual has met the criteria above for initial or continuing treatment; **and**
B. The treatment plan should include treatment with a certified or licensed physician, qualified healthcare provider, or ABT technician (in accordance with state law and benefit plan requirements) for 40 hours per week or less; **and**
   Note: ABT services for more than 40 hours per week have not been shown to be more effective and documentation as to why more than 40 hours per week is planned must be provided.
C. A certified or licensed physician, qualified healthcare provider (in accordance with state law and benefit plan requirements) provides protocol modification; **and**
D. The hours of services should reflect the number of behavioral targets, services, and key functional skills to be addressed, with a clinical summary justifying the hours requested for each behavioral target. The total hours of ABT requested should be comprised of fewer than 40 hours per week.

Protocol modification of ABT treatment may be **covered** for an individual with ASD **when** a state mandate requires or a benefit plan explicitly provides coverage for ABT and **ALL** of the following **selection criteria** are met:

A. The individual has met the criteria above for an initial course of ABT; **and**
B. The professional is an appropriate provider who is licensed or certified according to the requirements of applicable state laws and benefit plan requirements to perform the protocol modification of services; **and**
C. Up to two (2) hours of protocol modification will be covered for every ten (10) hours of direct ABT therapy. Any greater frequency of protocol modification will require written documentation demonstrating the need for additional protocol modification.

Group adaptive behavior treatment may be **covered** when all of the following criteria have been met:

A. The *person-centered treatment plan* addresses specific treatment goals and targeted problem areas; **and**
B. The goal is to train a group of individuals in the use of behavioral techniques to reduce maladaptive behaviors and skill deficits; **and**
C. The session is conducted by a certified or licensed physician, qualified healthcare provider, or ABT technician (in accordance with state law and benefit plan requirements); **and**
D. The individual has sufficient social, language, and adaptive skills to participate in group adaptive behavior treatment; **and**

E. The hours of services should reflect the number of behavioral targets, services, and key functional skills to be addressed, with a clinical summary justifying the hours requested for each behavioral target. The total hours of group adaptive behavior treatment requested should be included in the 40 hours per week.

Adaptive behavior treatment social skills group may be **covered** when all of the following criteria have been met:

A. The *person-centered treatment plan* addresses specific treatment goals and targeted problem areas; **and**
B. The goal is to train a group of individuals in the use of social skills to reduce maladaptive behaviors and skill deficits; **and**
C. The session is conducted by a certified or licensed physician, qualified healthcare provider (in accordance with state law and benefit plan requirements); **and**
D. The individual has sufficient social, language, and adaptive skills for the individual to participate in group adaptive behavior treatment; **and**
E. The hours of services should reflect the number of behavioral targets, services, and key functional skills to be addressed, with a clinical summary justifying the hours of social skills group. The total hours of group adaptive behavior treatment requested should be included in the 40 hours per week.

Family adaptive behavior treatment guidance may be **covered** when all of the following criteria have been met:

A. The goal of the guidance is to provide instruction to a parent, guardian, or other caregiver the treatment protocols to use in reducing maladaptive behaviors; **and**
B. The *person-centered treatment plan* addresses targeted behaviors and specific goals based on assessment of the affected individual; **and**
C. The scope of the intervention for the targeted behaviors is within the context of management by the family and is such that the guidance must be performed in the absence of the affected individual.

Multiple-family group adaptive behavior treatment guidance may be **covered** when all the following criteria have been met:

A. The *person-centered treatment plan* addresses specific treatment goals and targeted problem areas; **and**
B. The goal is to train a group of parents, guardians, or caregivers in the use of behavioral techniques to reduce maladaptive behaviors and skill deficits; **and**
C. The session is conducted by a certified or licensed physician, qualified healthcare provider (in accordance with state law and benefit plan requirements); **and**
D. The intervention is based upon the affected individuals sharing at least one common behavioral target and possible key functional skills that will benefit the individual by group intervention as explained in the clinical summary; **and**
E. The scope of the intervention for the targeted behaviors is within the context of management by the families and is such that the guidance must be performed in the absence of the affected individual.

Exposure adaptive behavior treatment with protocol modification may be **covered** when all of the following criteria have been met:

A. The *person-centered treatment plan* details the treatment goals for the exposure treatment, describing the type, severity, and frequency of the specific non-redirectable disruptive behaviors that pose significant risk of harm to the individual or others present; **and**
B. The intervention request should specify the services and key functional skills to be included for the target(s); **and**
C. The treatment is administered by a certified or licensed physician, qualified healthcare provider, with two or more technicians for safe treatment in a setting conducive to the safety of the individual and other people who may be present; **and**
D. The total hours of exposure adaptive behavior treatment, and exposure adaptive behavior treatment with protocol modification requested should be comprised of fewer than 10 hours per week. If additional

treatment time is requested a rationale must be provided with the request describing the specific situation that warrants additional time; **and**

E. The hours of exposure adaptive behavior treatment requested should be included in the total hours of ABT requested.

III. Continuation of treatment

Continuation of ABT treatment may be **covered** for an individual with ASD **when** a state mandate requires or a benefit plan explicitly provides coverage for ABT and **ALL** of the following **selection criteria** are met:

A. The individual continues to meet the criteria above for an initial course of ABT; **and**
B. The *person-centered treatment plan* will be updated and submitted, in general, every 6 months or as required by a state mandate. **Note:** Treatment plans may be required more often than every 6 months, for example, when exposure behavioral follow-up assessment or exposure behavioral ABT with protocol modification are required; **and**
C. The *person-centered treatment plan* includes age and impairment appropriate goals and measures of progress. The treatment plan should include measures of the progress made with social skills, communication skills, language skills, adaptive functioning, and specific behaviors or deficits targeted. Clinically significant progress in social skills, communication skills, language skills, and adaptive functioning must be documented as follows:
    1. Interim progress assessment at least every 6 months based on clinical progress toward treatment plan goals; **and**
    2. Developmental status as measured by standardized assessments no less frequent than every 2 years*; **and**
D. For each goal in the *person-centered treatment plan,* the following is documented:
    1. Progress-to-date relative to baseline measures is described; **and**
    2. Anticipated timeline for achievement of the goal(s), based on both the initial assessment and subsequent interim assessments over the duration of the intervention; **and**
    3. Family education and training interventions including the behavior parents/caregivers are expected to demonstrate and utilize outside the treatment setting (for example, at home or in the community); **and**
    4. Estimated date of mastery; **and**
    5. Plan for generalization; **and**
    6. Transition and discharge planning.

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

E. Benefit from ABS is expected to be reached within 3 years of therapy. Additional therapy beyond 3 years does not show to have additional clinical improvement and may not be authorized. Other therapies may be offered. (State of Georgia Medicaid)

F. If an individual is unable to demonstrate progress toward meeting the majority of goals after two six month periods of ABS treatment, then consideration will be given as to whether or not there is a reasonable expectation that the child is capable of making progress with ABS. If so, then the individual no longer meets criteria for continued ABS therapy and other modalities may be offered. (State of Georgia Medicaid)

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G Transition and discharge planning. The treatment should NOT be making symptoms worse, or showing as regression in any additional therapies targeting skill acquisition (understanding the importance of coordinating ABS services with any other modality/service/therapy being received by the child at the same time). There must be a reasonable expectation that the child will continue to benefit from the continuation of ABS services and that continuation is NOT for the benefit of the family, caregivers or treating therapist. (State of Georgia Medicaid)

* Systematic and repeated evaluation of developmental status is critical to assessing the effect of therapeutic treatments, including ABT. The use of standardized assessments facilitates the consistent, systematic, and reliable evaluation early in the course of treatment, preferably before initiating ABT, and at regularly scheduled intervals thereafter. The data derived from these assessments is used to inform about the impact of treatment on the trajectory of the individual's condition, especially documenting improvement. Examples of widely accepted and used standardized assessments include the VB-MAPP and the Vineland.

IV. When Above Criteria Are Not Met

To the extent there is a state mandate or specific benefit coverage for ABT for an individual that allows ABT treatment to be reviewed using clinical criteria, ABT will be considered not covered and **not medically necessary** when either:

A. The criteria above are not met; **or**
B. There is no documentation of clinically significant progress in any of the following areas as measured by an interim progress evaluation through standardized assessments:
    1. Adaptive functioning; **or**
    2. Communication skills; **or**
    3. Language skills; **or**
    4. Social skills.

V. Other Information:

Cognitive, developmental or intelligence quotient (IQ) testing is not required for an initial or continued course of ABT treatment to be covered.

Coding

The following codes for treatments and procedures applicable to this document are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Note: There are no specific procedure codes for ABT. The following list of procedure codes are examples only and may not represent all codes being used for ABT. Please contact the member's plan for applicable coding conventions as these may vary.

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CPT	
0359T	Behavior identification assessment, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report
0360T	Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-to-face with the patient
0361T	Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; each additional 30 minutes of technician time, face-to-face with the patient
0362T	Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; first 30 minutes of technician(s) time, face-to-face with the patient
0363T	Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; each additional 30 minutes of technician(s) time, face-to-face with the patient
0364T	Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; first 30 minutes of technician time
0365T	Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; each additional 30 minutes of technician time
0366T	Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time
0367T	Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; each additional 30 minutes of technician time
0368T	Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; first 30 minutes of patient face-to-face time
0369T	Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; each additional 30 minutes of patient face-to-face time
0370T	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)
0371T	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)
0372T	Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face-to-face with multiple patients
0373T	Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians' time, face-to-face with patient
0374T	Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); each additional 30 minutes of technicians' time, face-to-face with patient
HCPCS	
	For the following codes, when specified as ABT therapy:

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G9012	Other specified case management services not elsewhere classified
H0031	Mental health assessment by non-physician [when specified as functional assessment and treatment plan developed for Adaptive Behavioral Treatment (ABT) services by a Qualified Autism Service Provider (licensed clinician or Board Certified Behavioral Analyst (BCBA)]
H0032	Mental health service plan development by non-physician [when specified as supervision of a Qualified Autism Service Professional or Paraprofessional by a Qualified Autism Service Provider]
H0046	Mental health services, not otherwise specified [when specified as direct ABT services by a Qualified Autism Service Professional]
H2012	Behavioral health day treatment, per hour [when specified as direct ABT services by a Qualified Autism Service Provider]
H2014	Skills training and development, per 15 minutes [when specified as skill development, social skills group activity]
H2019	Therapeutic behavioral services, per 15 minutes [when specified as direct ABT services by a Qualified Autism Service Paraprofessional]
S5108	Home care training to home care client, per 15 minutes
S5110	Home care training, family; per 15 minutes

ICD-10 Diagnosis

F84.0	Autistic disorder
F84.2	Rett's Syndrome
F84.3	Other childhood disintegrative disorder
F84.5	Asperger's syndrome
F84.8	Other pervasive developmental disorders
F84.9	Pervasive developmental disorder, unspecified

Discussion/General Information

In May 2013, the APA released DSM-5. This edition of the DSM includes several significant changes over the previous edition, including combining several previously separate diagnoses under the single diagnosis of ASD. This diagnosis included the following disorders, previously referred to as: atypical autism, Asperger's disorder, childhood autism, childhood disintegrative disorder, early infantile autism, high-functioning autism, Kanner's autism, and PDD not otherwise specified. All of these conditions are now considered under one diagnosis, ASD. It should be noted that Rett Syndrome is not included in the new DSM-5 ASD diagnostic group.

The DSM-5 describes the essential diagnostic features of ASD as both a persistent impairment in reciprocal social communication and restricted and repetitive pattern of behavior, interest or activities. These attributes are present from early childhood and limit or impair everyday functioning. Parents may note symptoms as early as infancy, and the typical age of onset is before 3 years of age. Symptoms may include problems with using and understanding language; difficulty relating to or reciprocating with people, objects, and events; lack of mutual gaze or inability to attend events conjointly; unusual play with toys and other objects; difficulty with changes in routine or familiar surroundings, and repetitive body movements or behavior patterns. There are some exceptions to this, where in

some circumstances a child may exhibit normal development for approximately 2 years followed by a marked regression in multiple areas of function.

Children with ASD vary widely in abilities, intelligence, and behaviors. Some children do not speak at all, others speak in limited phrases or conversations, and some have relatively normal language development. Repetitive play skills, resistance to change in routine and inability to share experiences with others, and limited social and motor skills are generally evident. Unusual responses to sensory information, such as loud noises and lights, are also common. Affected children can exhibit unusual behaviors occasionally or seem shy around others sometimes without having ASD. What sets children with ASD apart is the consistency of their unusual behaviors. Symptoms of the disorder have to be present in all settings, not just at home or at school, and over considerable periods of time. With ASD, there is a lack of social interaction, impairment in nonverbal behaviors, and a failure to develop normal peer relations. A child with an ASD tends to ignore facial expressions and may not look at others; other children may fail to respect interpersonal boundaries and come too close and stare fixedly at another person.

ASDs, under the new DSM-5 paradigm, are now classified by Severity Level (see Table 2 below). Level 1, "Requiring support," is considered the least severe classification and includes individuals with mild deficits in social communications (as seen in individuals formerly diagnosed with Asperger's syndrome). Level 3, "Requiring very substantial support," is considered the most severe classification and includes individuals with no or extremely limited communication abilities.

The exact causes of autism are unknown, although genetic factors are strongly implicated. A study released by the Centers for Disease Control and Prevention (2012) indicates that the incidence of ASD was as high as 1 in 88 children.

The specific DSM-5 diagnostic criteria for ASD are provided below:

DSM-5 Criteria for Autism Spectrum Disorder*

Diagnostic criteria

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive; see text);
    1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
    2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication, to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communications.
    3. Deficits in developing, maintaining and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social context; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.
    Specify current severity:
    Severity is based on social communication impairments and restricted, repetitive patterns of behavior (See table 2).
B. Restricted, repetitive patterns of behavior, interests, or activities as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text);
    1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
    2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).

3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
4. Hyper- or hypo-activity to sensory inputs or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching or objects, visual fascination with lights or movement).
   Specify current severity:
   Severity is based on social communication impairments and restricted, repetitive patterns of behavior (See table 2).

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learning strategies in later life).
D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.
E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

Note: Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder.

Specify current severity:
With or without accompanying intellectual impairment
With or without accompanying language impairment
Associated with a known medical or genetic condition or environmental factor. (Coding note: Use additional code to identify the associated medical or genetic condition)
Associated with another neurodevelopmental, mental, or behavioral disorder. (Coding note: Use additional code[s] to identify the associated neurodevelopmental, mental, or behavioral disorder)
With catatonia (refer to the criteria for catatonia associated with another mental disorder, pp. 119-120 for definition**). (Coding note:** Use additional code 293.89 [F06.1] catatonia associated with autism spectrum disorder to indicate the presence of the comorbid catatonia).

*From: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. DSM-5. American Psychiatric Association. Washington, DC. May 2013. Pages 50-51.

Table 2 Severity levels for autism spectrum disorders*

Severity Level	Social Communication	Restricted, repetitive behaviors
Level 3 "Requiring very substantial support"	Severe deficits in verbal and nonverbal social communications 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 or 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 changing focus or action.
Level 2 "Requiring substantial support"	Marked deficits in verbal and nonverbal communication skills; social impairments apparent even with	Inflexibility of behavior, difficulty coping with change, or other restricted / repetitive behaviors appear frequently

	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 interests, and who has markedly odd nonverbal communication.	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 sentences and engages in communications but whose to-and-fro conversation with others fails, and whose attempts to make friends are odd and typically unsuccessful.	Inflexibility of behavior causes significant interference with functioning in one or more context. Difficulty switching between activities. Problems of organization and planning hamper independence.

* From: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. DSM-5. American Psychiatric Association. Washington, DC. May 2013. Page 52.

The treatment of ASD may take many different approaches, focusing on one or more aspects of the condition being treated. There is no single treatment that has consistently demonstrated benefit at the core symptoms of these disorders. Family therapy is generally supported as a valuable treatment because it offers emotional support and guidance to parents who will contend with a myriad of services to assist their child. Individual therapy using social story technique and behavioral cue coaching are very useful for the older child/adolescent with Asperger's syndrome and can make a difference in that child's acceptance by others. Educational therapy includes intensive one-on-one therapy involving a wide array of techniques focusing on improvement in social, communication, and language skills, and may include ABT.

ABT should be part of person-centered treatment plan that addresses the whole person. The plan is developed based on assessments of the individual's behavioral, psychological, family, and medical health. The use of ABT begins with a thorough assessment of the individual for whom the treatment is requested. This assessment should include confirmation of a diagnosis of ASD made by a licensed medical professional, licensed psychologist, or other qualified health care professional. The evaluation of motor, language, social, adaptive, and/or cognitive functions is important to understand the individual's baseline status and potential for improvement (Maglione, 2012). State mandates may limit the assessments that a health plan may require.

In order to assure accurate measurement of progress and outcomes, the treatment plan must utilize measurable goals in objective and measurable terms based on standardized assessments that address the behaviors and impairments for which the intervention is to be applied (Maglione, 2012). The use of standardized assessments in a systematic and repeated manner is critical to the proper and consistent measurement of an individual's response to treatment. Standardized assessments, as opposed to non-standardized assessments, are important because standardized assessments have been demonstrated to be consistent, reliable, and widely available. Furthermore, many have been validated for clinical accuracy as well. The use of standardized assessments early in the course of treatment, preferably before initiating treatment and at regularly scheduled intervals thereafter, provides information about any impact of treatment on developmental trajectory, especially documenting improvement. Examples of widely accepted and used standardized assessments include the VB-MAPP and the Vineland. These types of assessments

usually consist of multiple sets of questions focusing on a variety of different developmental areas including, physical, language, social, and learning, and are intended to provide a clinical picture of an individual at a particular point in time.

The assessments characteristic of ABT can be classified into 3 types. A *behavior identification assessment* is used to identify behavioral issues that may be targeted for specific interventional treatment. There are many different assessment tools available for this type of assessment, and utilization of such a tool is critical for the proper identification and evaluation of behavioral issues. Examples of such tools include the VB-MAPP and the Vineland. Another assessment that may be required is an *observational behavioral assessment.* This type of assessment is used in the identification and evaluation of disruptive behaviors such as repetitive gestures, head banging, angry or violent outbursts, etc. According to the Behavior Analyst Certification Board (BCAB) document titled, *Applied Behavior Analysis Treatment for Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers* (2014), this initial assessment should take approximately 20 hours. Additionally, these assessments may need to be repeated during the treatment period, but are likely to take considerably less time to complete when repeated. An *exposure behavioral assessment* may be needed to further assess and characterize disruptive behaviors in order to understand social or environmental triggers of disruptive behaviors. Safety is very important. The environment in which these types of assessments are conducted should be carefully controlled, including the persons present at the time of evaluation. This is important in order to control for potential confounding elements that may interfere with proper assessment. Additionally, because aggressive or violent behaviors are often the types of disruptive behaviors for which this type of assessment is needed, there may be considerably risk to those present during the assessment period. In order to control for possible risk of harm, the assessment should be conducted in an environment that is away from areas that put others at unnecessary risk.

According to the BACB's 2014 guideline, comprehensive ABT should include one-on-one treatment with a certified or licensed physician, qualified healthcare provider, or ABT technician of between 30 to 40 hours per week. This recommendation is joined by the recommendations made in guidelines addressing non-medical interventions published by the Health Resources and Services Administration (HRSA, Maglione, 2012), which states that "Children with ASD should be actively engaged in comprehensive intervention for a minimum of 25 hours per week throughout the year." They support this with the comment that "the vast majority of high-quality behavioral interventions found in the literature required 20 to 40 hours of treatment per week."

Comprehensive treatment, including ABT, refers to treatment of the multiple affected developmental domains, such as cognitive, communicative, social, emotional, and adaptive functioning. Maladaptive behaviors, such as noncompliance, tantrums, and stereotypical actions are also typically the focus of treatment (Maglione, 2012). Comprehensive ABT treatment may be referred to as *adaptive behavior treatment* or *adaptive behavior treatment with protocol modification.*

Comprehensive ABT may involve several additional focused treatment methods tailored to address specific aspects of the individual's condition. According to the BACB's guidelines, focused treatments generally involve between 10 and 25 hours per week. One type of focused treatment is *group adaptive behavior treatment,* which targets maladaptive behaviors and skill deficits in a group setting. According to the HRSA, such group therapy has been found to be especially effective in older children (Maglione, 2012). Another type of focused treatment is *family adaptive behavior treatment guidance,* which is tended to provide instruction to a parent, guardian, or other caregiver in the treatment protocols designed to reduce maladaptive behaviors. *Multiple-family group adaptive behavior treatment guidance* is intended for the same purpose, but the goal is to train a group of parents, guardians, or caregivers together. These types of family-oriented therapies are recommended in HRSA guidelines (Maglione, 2012). *Exposure adaptive behavior treatment with protocol modification* is intended to focus on the treatment of specific disruptive behaviors such as gesturing or aggression.

Many of the treatments utilized in ABT are conducted by behavior analysts and technicians who may not be licensed, depending upon the laws and regulatory requirements of the area in which they are practicing. Supervision of behavior analysts and technicians by a licensed or certified professional is a requirement in the 2014 BACB guidelines, which states 2 hours of supervision for every 10 hours of direct treatment is the general standard of care.

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The continuation of ABT is based upon the individual's continuing to meet the criteria used to qualify the initial course of treatment. Additionally, is it critical that the individual's person-centered treatment plan be updated, generally every 6 months, or as required by a state mandate, to provide adequate track of the individual's progress. Exposure assessments and interventions should suggest changes in the treatment plan because these evaluations and interventions are particularly intense and indicated when behavior poses a safety risk. The person-centered treatment plan should include age-specific and impairment appropriate goals and measures of progress as well as measures of the progress made with social skills, communication skills, language skills, adaptive functioning, and specific behaviors or deficits targeted. The measurement of progress in social skills, communication skills, language skills, and adaptive functioning should be measured by standard scores using standardized assessments no less frequent than every 2 years.

Finally, the benefit of ABT in the absence of clinically significant developmental progress has not been demonstrated in the peer-reviewed published literature. When no measurable benefit has been discerned through accepted and validated measurement tools, the use of ABT is not warranted.

Definitions

Note: State mandates or certificate language may define these terms more or less broadly than below; consult applicable mandates and certificates when applying this guideline.

Adaptive Behavior Treatment (ABT): ABT refers to the process of applying interventions that are based on the principles of learning derived from experimental psychology research to systematically change behavior and to demonstrate that the interventions used are responsible for the observable improvement in behavior. ABT methods are used to increase and maintain desirable adaptive behaviors, reduce interfering maladaptive behaviors or narrow the conditions under which they occur, teach new skills, and generalize behaviors to new environments or situations. ABT focuses on the reliable measurement and objective evaluation of observable behavior within relevant settings including the home, school, and community. Applied Behavioral Analysis (ABA) is one type of ABT (Meyers, 2007).

Assessment instruments: Specialized and standardized diagnostic test used to evaluate an individual's performance in specific areas of functioning such as those recommended in the guidelines of the AAP, AAN and the AACAP (e.g., learning and communications skills, social interaction, etc.).

Autism spectrum disorder: A collection of associated developmental disorders that affect the parts of the brain that control social interaction and verbal and non-verbal communication.

Behavior modification: A therapy type that is designed to create new behavior patterns in people through intensive and frequent feedback using a reward, non-reward system.

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

Oversight/supervision of treatment: ABT is usually conducted by many different individuals, all of whom are tasked with implementing a treatment plan created by a licensed or certified behavioral analyst. To assure that the treatment plan is being properly and effectively implemented, the licensed or certified provider is required to conduct regular direct supervision sessions of the individuals conducting the ABT treatments specified by the treatment plan for the individual with an autism spectrum disorder.

Qualified health care professional: An individual who has earned the appropriate education, training, certifications and/or licensure in a field related to the treatment of autism and is considered qualified under the laws of their state to be qualified to oversee ABT.

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Applied Behavioral Analysis (ABA)
Asperger's Syndrome
Autism
Early Intensive Behavior Intervention (EIBI)
Intensive Behavior Intervention (IBI)
Lovaas Therapy
Pervasive Developmental Disorder (PDD

History

Status	Date	Action
Reviewed	04/19/2018	Approved by MOC
Revised	02/12/2018	State of Georgia notification of changes made by the state of Georgia for use with Georgia Medicaid members. Revised Assessment and Planning emphasis on other relevant conditions. Revised Continuation of treatment to indicate response expectations.
Reviewed	08/03/2017	Medical Policy & Technology Assessment Committee (MPTAC) review.
Reviewed	07/21/2017	Behavioral Health Subcommittee review. Updated References section.
Revised	08/04/2016	MPTAC review.
Revised	07/29/2016	Behavioral Health Subcommittee review. Created new section titled "When Above Criteria Are Not Met" and placed related text within that section. Added text regarding state mandates. Updated formatting in the Clinical Indications section. Updated the Description, Discussion, Definitions, and References sections.
Revised	12/16/2015	MPTAC review.
Revised	12/11/2015	Behavioral Health Subcommittee review. Revised Clinical Indications section regarding use of assessments. Updated Coding, Discussion/General Information and References sections. Removed ICD-9 codes from Coding section.
Revised	08/06/2015	MPTAC review.
Revised	07/31/2015	Behavioral Health Subcommittee review. Revised and restructured Clinical Indications section. Updated Background, Definitions, and References sections.
Reviewed	02/05/2015	MPTAC review.
Reviewed	01/30/2015	Behavioral Health Subcommittee review. Description and References updated.
	07/01/2014	Updated Coding section with 07/01/2014 CPT changes.
Reviewed	02/13/2014	MPTAC review.
Reviewed	02/07/2014	Behavioral Health Subcommittee review.
New	11/14/2013	MPTAC review.
New	10/18/2013	Behavioral Health Subcommittee review. Initial document development.

Federal and State law, as well as contract language including definitions and specific coverage provisions/exclusions, and Medical Policy take precedence over Clinical UM Guidelines and must be considered first

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in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Clinical UM Guidelines, which address medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Clinical UM Guidelines periodically. Clinical UM guidelines are used when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether or not to adopt a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the back of the member's card.