KAISER PERMANENTE®

Applied Behavioral Analysis Therapy (ABA)

Effective until October 1, 2021

For all Kaiser Permanente plans with a benefit (except Microsoft)

ABA requires preauthorization for initial and continued therapy. Specific coverage may be defined in the individual member contract. The following criteria must be met:

1. The member has a diagnosis of an Autism Spectrum Disorder (DSM-V code including severity levels) by a neurologist, pediatric neurologist, developmental pediatrician, psychologist, or psychiatrist experienced in the diagnosis and treatment of autism, or, has a developmental disability for which there is evidence that ABA therapy is effective.
2. The diagnostic assessment must include **All of the following** elements:
    a. Documentation of formal diagnostic procedures by an experienced clinician (e.g., Autism Diagnostic Interview-Revised, Autism Diagnostic Observation Schedule, diagnostic interview using DSM-V criteria)
    b. Description of how patient's behaviors are having an impact on development, communication or adjustment such that:
        i. The member cannot adequately participate in home, school, or community activities; and/ or the member presents a safety risk to self or others, and
        ii. Less intrusive and/or less intensive behavioral interventions have been tried and have not been successful and/or there is no equally-effective alternative strategy available to address the member's behaviors
    c. Specific evaluations to determine developmental profile using **ONE or more of the following** standard tools:
        i. Adaptive/Functional skills: Vineland Adaptive Behavior Scales
        ii. Communication skills: Preschool Language Scale-5 (PLS-5), Clinical Evaluation of Language Fundamentals-5 (CELF-5), Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP)
        iii. Cognitive Assessment (Wechsler scales, Kaufman scales)
        iv. Social Skills Rating Scales (SSRS), Assessment of Basic Language and Learning Skills (ABLLS), Achenbach System of Empirically Based Assessment (ASEBA)
        v. Behavior rating scales: ASEBA, Behavior Assessment System for Children, Third Ed. (BASC-3), Gilliam Autism Rating Scale
    d. Expanded laboratory, documented routine developmental surveillance by providers at every well child visit, screening questionnaire, audiology assessment results, only if indicated.

3. A documented individualized treatment plan (ITP) that includes:
    a. A time-limited ITP that has been developed based on a diagnostic assessment within no more than 12 months of initiating treatment
    b. ITP is multidisciplinary in nature, member-centered, family-focused, community-based, culturally-competent and least intrusive
    c. Treatment plans that are templates or generic to a particular program are not acceptable
    d. The ITP must address behaviors and symptoms that prevent the member from adequately participating in home, school, or community activities and/or present a safety risk to self or others, with a focus on parent training
    e. The ITP should take into account all school or other community resources available to the patient and

provide evidence that the requested services are not redundant to other services already being provided. The ITP should include a review of a school-based IEP (if present) and how the ITP does not duplicate what is on the IEP. The ITP should also include a review of other treatment if present (e.g., outpatient mental health, speech therapy) and how the ITP does not duplicate these community-based resources. Coordination between the ABA provider and school and/or other service providers must take place directly between the providers, and not through parents.

f. Coverage of ABA therapy in public or private schools is only provided under the following circumstances:
   i. Observation and assessment of behavior may take place in the school as part of the ITP assessment with the permission of school personnel
   ii. ABA may be provided on school property before and after regular school hours with the permission of school personnel
   iii. ABA may be provided during regular school hours with permission of school, when medically necessary, and the ABA intervention does not duplicate services the school could be expected to provide.

4. The ITP must include **All of the following**:
   a. Description of autistic behaviors that are targets for treatment. The targets for treatment should be based on where there is the most significant gap in functioning as measured by developmental and behavioral assessment including **ONE or more of the following:**
      i. Adaptive/Functional skills: Vineland Adaptive Behavior Scales
      ii. Communication skills: Preschool Language Scale-5 (PLS-5), Clinical Evaluation of Language Fundamentals-5 (CELF-5), Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP)
      iii. Cognitive Assessment (Wechsler scales, Kaufman scales)
      iv. Social Skills Rating Scales (SSRS), Assessment of Basic Language and Learning Skills (ABLLS), Achenbach System of Empirically Based Assessment (ASEBA)
      v. Behavior rating scales: ASEBA, Behavior Assessment System for Children, Third Ed., (BASC-3)
   b. A comprehensive description of treatment interventions and techniques specific to each of the targeted behavioral/symptoms
   c. Establishment of treatment goals and objective measures of progress for each intervention specified (including baseline and targeted goals)
   d. Strategies for generalizing learning skills
   e. A description of parental education, goals, training and support services to include specific detailed description of interventions with parents to support their active participation in ABA treatment, including a plan for transferring interventions with the patient to the parents
   f. Strategies for communication and coordinating treatment with other providers and agencies including school-based special education programs, day care, and other health care providers
   g. Hours requested for each treatment modality (e.g., parent training, paraprofessional time, lead behavior therapist, supervision, social skills group, completion of six-month progress report)
   h. Measurable discharge criteria for completing treatment and plans for continued care after a discharge plan from ABA, which include **All of the following**:
      i. Plans for transition through a continuum of less intensive treatments such that patient's symptoms can be effectively managed at a lower level of care
      ii. Specific behavioral goals that, when reached, will indicate the patient is adequately participating in home, school, or community activities and/or is no longer presently a safety risk to self or others
5. Discharge Criteria - Typically individuals no longer need ABA services if **ONE of the following** is met:
   a. Their behaviors and/or symptoms do not prevent them from adequately participating in home, school, or community activities and/or no longer present a safety risk to self or others
   b. Their behaviors and/or symptoms can be adequately addressed through alternative methods (i.e. school, developmental disability services, parent training)
   c. Functional and measurable progress toward treatment goals is not occurring (majority of goals are not being met, there is not significant progress on behaviors and/or symptoms that prevent them from adequately participating in home, school, or community activities, and/or no longer present a safety risk to self or others), improvement is not durable over time, and generalizable outside the treatment setting, and there is no reasonable expectation of further progress
   d. Parents have not been active participants in ABA treatment

6. Coverage of development of the ITP does include time to do baseline assessments, review of past treatment (including IEPs) and development of a plan that includes parent training and coordination with other treatment providers. Six to 10 hours is usually sufficient for the development of the ITP. However, more complex cases, or cases in which a complete functional analysis is needed, may require up to 15-20 hours for the initial assessment and treatment planning.

7. As noted in the 2014 Agency for Healthcare Research and Quality update on A Review of Research of Therapies for Children with Autism Spectrum Disorder, early intervention programs (i.e. for children typically, under the age of six) are provided for up to 25 hours a week and can last as long as 12 weeks to 3 years. These services can include direct services to member/identified patient and/or parents by program manager/lead behavioral therapist and/or therapy assistants/behavioral technicians/paraprofessionals, supervision, and the development of a six-month progress report.
8. Fewer hours may be required (5-15 hours per week) for Focused ABA when the primary difficulty is in one targeted area (i.e. social skills deficits).

9. Evaluation of progress: At least every six months, provide a summary outlining the member's progress based on the established ITP measures of progress including the following information:
    a. How patient is progressing towards goals (i.e. what percentage of goals patient has achieved and how these goals have led to functional progress as it pertains to increasing patient's ability to adequately participate in home, school, or community activities, and/or decrease safety risk to self or others
    b. Progress towards parent goals (how parents have been active participants in the treatment, what percentage of parent goals have been passed, and progress towards transferring interventions with the patient to the parents)
    c. For goals that have not been met, describe reason for not meeting goals, how goals are being adjusted, and how interventions are being revised to meet goals
    d. Any new goals that have been identified (if new goals are identified, include baseline and targeted performance). New goals should be geared towards progress or transition to less intensive interventions
    e. How the patient is progressing towards discharge and/or plans for discharging from care and/or reducing intensity of intervention based on patient progress and/or the implementation of less intensive behavioral interventions
    f. A brief description of what was done during the past six months to coordinate treatment with school and/or health care providers (i.e. phone call was made to speech therapist to make sure there is common picture communication system; a conference was held with the school to coordinate behavioral interventions for self-injurious behavior). This coordination must take place directly between the ABA provider and any other service providers, and not through the parents
    g. If functional progress is not occurring (i.e. every six months patient is not meeting majority of goals and not making significant progress towards increased participation in home, school, or community activities and/or is not less of a safety risk to self or others) and there is not a reasonable expectation of further progress, then continuation of ABA services is not considered to be medically necessary

10. Every 12 months, developmental assessment should be re-administered to assess whether patient continues to be making functional and measurable progress.

11. The following are not considered to be medically necessary ABA services:
    a. More than one program manager/lead behavioral therapist for a member/identified patient at any one time.
    b. More than one agency/organization providing ABA services for a member/identified patient at any one time.
    c. If the school has determined that a child is eligible to receive services under an IEP which would overlap with ABA services and the school services are declined or discontinued by the parent.
    d. Activities and therapy modalities that do not constitute application of applied behavioral analysis techniques for treatment of autism. Examples include (but not limited to):
        i. Taking the member/identified patient to appointments or activities outside of the home (e.g. recreational activities, eating out, shopping, play activities, medical appointments),

except when the member/identified patient has demonstrated a pattern of significant behavioral difficulties during such specific activities

ii. Assisting the member/identified patient with academic work or functioning as a tutor, educational or other aide for the member/identified patient in school

iii. Provision of services that are part of an IEP and therefore should be provided by school personnel, or other services that schools are obligated to provide

iv. Doing house work or chores, or assisting the member/identified patient with house work or chores, except when the member has demonstrated a pattern of significant behavioral difficulties during specific house work or chores, or acquiring the skills to do specific house work or chores is part of the ABA treatment plan for the member/identified patient

v. travel time

vi. residing in the member's home and functioning as live-in help (e.g. in an au-pair role)

12. All ABA visits with the patient and/or family should be documented to include:
    a. Who was present at the visit?
    b. Duration of the visit
    c. What was the targeted behavior during the visit?
    d. What was the procedure/activity/intervention during visit?
    e. What was the response to procedure/activity/intervention?
    f. Intervention format (individual, group, supervision, parent training)
    g. Graphical or numerical data to track progress/participation
    h. Signature title, credentials of person completing documentation
    i. Include targeted behavior, interventions, response, modifications in techniques and plan for next visit with behavior tracking sheets that record and graph data collected for each visit

ABA Provider Qualifications and Procedure Codes

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

a. At a minimum, the lead behavioral therapist, providing treatment and clinical supervision of treatment program must demonstrate that she/he is a board certified behavior analyst (BCBA) or must demonstrate that the she/he has at least 240 hours of coursework related to behavior analysis and/or 750 hours of supervised experience or 2 years of practical experience in designing and implementing comprehensive behavioral analytic therapies for children with autism; ***and***

b. ***Either***:
    i) Individually satisfy **ALL of the following** requirements:
        1. Be a licensed health provider under Title 18, Revised Code of Washington, including but not limited to: speech therapist, occupational therapist, psychologist, pediatrician, neurologist, psychiatrist, mental health counselor, social worker; and
        2. Be licensed to practice independently; and
        3. Be credentialed and contracted by the Plan; ***or***
    ii) Be employed by a Healthcare Delivery Organization that meets **All of the following** requirements:
        1. Be a hospital, mental health facility, home health agency or in-home agency licensed to provide home health services, or other mental health agency licensed by the Washington Department of Health; ***or*** a community mental health agency or home health agency licensed by the Washington Department of Social and Health Services; and
        2. Be credentialed and contracted by the Plan.

c. Clinical supervision for unlicensed staff providing services must be provided by a lead behavioral therapist as indicated above. Such supervision must:
    i) Include bimonthly (once every 60 days) approval and review of the ITP and case review of every member receiving clinical health services; and
    ii) Include at least one hour of on-site supervision, with on-site observation for at least one hour for every 40 hours of service to the member.

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

HCPCS		
Codes	**Number**	**Description**
	H2017	Provision of ABA services by lead behavioral therapist to patient to include direct one to one services, face to face parent training as well as supervision of unlicensed provider per 15 minutes
	0362T	Behavior identification supporting assessment, face-to-face with patient, requiring the following: (1) administration by physician or other qualified healthcare professional who is on site, (2) assistance of two or more technicians, (3) for a patient who exhibits destructive behavior, and (4) completed in an environment customized to the patient's behavior.
	0373T	Adaptive behavior treatment with protocol modification requiring the following: (1) administered by physician or other qualified healthcare professional who is on site, (2) assistance of two or more technicians, (3) for a patient who exhibits destructive behavior, and (4) completed in an environment customized to the patient's behavior.
	97151	Behavior identification assessment, administered by a physician or other QHCP, each 15 minutes of the physician's or other QHCP time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan.
	97152	Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes.
	97153	Adaptive behavior treatment by protocol, administered by technician under direction of a physician or other qualified healthcare professional, face-to-face with one patient.
	97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes.
	97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes.
	97156	- Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes.
	97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes.

97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes.
97153 (with HO modifier)	Adaptive behavior treatment by protocol, administered by physician or other qualified health professional, face-to-face with one patient.

Effective October 1, 2021

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

1. The member has a diagnosis of an Autism Spectrum Disorder (DSM-V code including severity levels) by a neurologist, pediatric neurologist, developmental pediatrician, psychologist, psychiatrist, or nurse practitioner experienced in the diagnosis and treatment of autism, or, has a developmental disability for which there is evidence that ABA therapy is effective.
2. The diagnostic assessment must include **All of the following** elements:
    a. Documentation of formal diagnostic procedures by an experienced clinician (e.g., Autism Diagnostic Interview-Revised, Autism Diagnostic Observation Schedule, diagnostic interview using DSM-V criteria)
    b. Description of how patient's behaviors are having an impact on development, communication or adjustment such that:
        i. The member cannot adequately participate in home, school, or community activities; and/ or the member presents a safety risk to self or others, and
        iii. Less intrusive and/or less intensive behavioral interventions have been tried and have not been successful and/or there is no equally-effective alternative strategy available to address the member's behaviors
    c. Specific evaluations to determine developmental profile using **ONE or more of the following** standard tools:
        i. Adaptive/Functional skills: Vineland Adaptive Behavior Scales
        ii. Communication skills: Preschool Language Scale-5 (PLS-5), Clinical Evaluation of Language Fundamentals-5 (CELF-5), Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP)
        iii. Cognitive Assessment (Wechsler scales, Kaufman scales)
        iv. Social Skills Rating Scales (SSRS), Assessment of Basic Language and Learning Skills (ABLLS), Achenbach System of Empirically Based Assessment (ASEBA)
        v. Behavior rating scales: ASEBA, Behavior Assessment System for Children, Third Ed. (BASC-3), Gilliam Autism Rating Scale
    d. Expanded laboratory, documented routine developmental surveillance by providers at every well child visit, screening questionnaire, audiology assessment results, only if indicated.
    e. There is evidence that the patient is capable of participating in ABA therapy
3. A documented individualized treatment plan (ITP) that includes:
    a. A time-limited ITP that has been developed based on a diagnostic assessment within no more than 12 months of initiating treatment
    b. ITP is multidisciplinary in nature, member-centered, family-focused, community-based, culturally-competent and least intrusive
    c. Treatment plans that are templates or generic to a particular program are not acceptable
    d. The ITP must address behaviors and symptoms that prevent the member from adequately participating in home, school, or community activities and/or present a safety risk to self or others, with a focus on parent training
    e. The ITP should take into account all school or other community resources available to the patient and provide evidence that the requested services are not redundant to other services already being provided. The ITP should include a review of a school-based IEP (if present) and how the ITP does not duplicate what is on the IEP. The ITP should also include a review of other treatment if present (e.g., outpatient mental health, speech therapy) and how the ITP does not duplicate these

community-based resources. Coordination between the ABA provider and school and/or other service providers must take place directly between the providers, and not through parents.

f. Coverage of ABA therapy in public or private schools is only provided under the following circumstances:
   i. Observation and assessment of behavior may take place in the school as part of the ITP assessment with the permission of school personnel
   ii. ABA may be provided on school property before and after regular school hours with the permission of school personnel
   iii. ABA may be provided during regular school hours with permission of school, when medically necessary, and the ABA intervention does not duplicate services the school could be expected to provide.

4. The ITP must include **All of the following**:
   a. Description of autistic behaviors that are targets for treatment. The targets for treatment should be based on where there is the most significant gap in functioning as measured by developmental and behavioral assessment including **TWO or more of the following:**

      ONE Norm-Referenced assessment is required to be completed during the initial ABA assessment, and to be readministered every 12 months. The provider is to use an instrument that will be suitable for serial measurements over time, and thus to measure functional progress over treatment periods. Some options for norm-based assessment are:

      - Vineland3 Adaptive Behavior Scales
      - Adaptive Behavior Assessment System (ABAS)
      - Pervasive Developmental Disorder Behavior Inventory (PDDBI)
      - Social Skills Improvement System (SSIS)

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

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

   b. A comprehensive description of treatment interventions and techniques specific to each of the targeted behavioral/symptoms
   c. Establishment of baseline data, measurable treatment goals, and criteria for goal attainment and objective measures of progress for each intervention specified (including baseline and targeted goals)
   d. Strategies for generalizing learning skills across persons and situations. Generalization plans are monitored closely as they are key to the patient transitioning to a lower level of care.
   e. A description of parent education, including measurable parenting goals with baseline and criteria for goal attainment, and description of interventions. The parent goals are to include instruction in ABA principles in order to training and support generalization and maintenance of skills. Detailed description of interventions with parents to support their active participation in ABA treatment, including a plan for transferring interventions with the patient from the ABA provider to the parents. An ITP that does not adequately feature parental involvement may be subject to denial.
   f. Strategies for communication and coordinating treatment with other providers and agencies including school-based special education programs, day care, and other health care providers
   g. Hours requested are itemized for each treatment modality (e.g., parent training, certified behavior technician time, lead behavior therapist, supervision, social skills group, completion of six-month progress report)
   h. Measurable discharge criteria for completing treatment and plans for continued care after a discharge plan from ABA, which include **All of the following**:
      i. Plans for transition through a continuum of less intensive treatments such that patient's

symptoms can be effectively managed at a lower level of care
   ii. Specific behavioral goals that, when reached, will indicate the patient is adequately participating in home, school, or community activities and/or is no longer presently a safety risk to self or others

5. Discharge Criteria - Typically individuals no longer need ABA services if **ONE of the following** is met:
   a. Patient behaviors and/or symptoms do not prevent them from adequately participating in home, school, or community activities and/or no longer present a safety risk to self or others
   b. Their behaviors and/or symptoms can be adequately addressed through alternative methods (i.e. school, developmental disability services, parent training)
   c. Functional and measurable progress toward treatment goals is not occurring as measured by (majority of goals are not being met, there is not significant progress on behaviors and/or symptoms that prevent them from adequately participating in home, school, or community activities, and/or no longer present a safety risk to self or others), improvement is not durable over time, and/or generalizable outside the treatment setting, and there is no reasonable expectation of further progress
   d. Parents have not been active participants in ABA treatment
6. Transition to a lower level of care. Discharge is often not a discrete event, but instead is a transitional process, to prevent relapse of skills. Transition to a lower level of care could include any of the following: lowered number of treatment hours (focused ABA), enhanced focus on training parents or other caregivers, or the use of other treatment modalities e.g., mental health counseling group treatments or other community support activities.
7. Coverage of development of the ITP does include time to do baseline assessments, review of past treatment (including IEPs) and development of a plan that includes parent training and coordination with other treatment providers. Six to 10 hours is usually sufficient for the development of the ITP. However, more complex cases, or cases in which a complete functional analysis is needed, may require up to 15-20 hours for the initial assessment and treatment planning.

8. The amount of treatment is based on medical necessity. As noted in the 2014 Agency for Healthcare Research and Quality update on A Review of Research of Therapies for Children with Autism Spectrum Disorder, early intervention programs (i.e. for children typically, under the age of six) are provided for up to 25 hours a week and can last as long as 12 weeks to 3 years. These services can include direct services to member/identified patient and/or parents by program manager/lead behavioral therapist and/or therapy assistants/behavioral technicians/paraprofessionals, supervision, and the development of a six-month progress report. In the unusual case of very acute and/or unsafe patient behavior, up to 40 hours/week of treatment may be authorized.
9. Fewer hours may be required (5-15 hours per week) for Focused ABA when the primary difficulty is in one targeted area (i.e. social skills deficits).

10. Evaluation of progress: At least every six months, the provider completes the KP ABA Progress Report Form. This document is used to review progress in treatment including the following information:
    a. How patient is progressing towards goals (i.e. what percentage of goals patient has achieved and how these goals have led to functional progress as it pertains to increasing patient's ability to adequately participate in home, school, or community activities, and/or decrease safety risk to self or others
    b. Progress towards parent goals (how parents have been active participants in the treatment, what percentage of parent goals have been passed, and progress towards transferring interventions with the patient to the parents)
    c. For goals that have not been met, describe reason for not meeting goals, how goals are being adjusted, and how interventions are being revised to meet goals
    d. Any new goals that have been identified (if new goals are identified, include baseline and targeted performance). New goals should be geared towards progress or transition to less intensive interventions.
    e. A criterion referenced assessment is to be submitted every six months.
    f. How the patient is progressing towards discharge and/or plans for discharging from care and/or reducing intensity of intervention based on patient progress and/or the implementation of less intensive behavioral interventions. A discharge plan stating that ABA will be needed until he/she no longer meets criteria for ASD is not appropriate. A patient could still meet diagnostic criteria for ASD but be able to be successfully and safely treated at a lower level of care.
    g. A brief description of what was done during the past six months to coordinate treatment with school

and/or health care providers (i.e. phone call was made to speech therapist to make sure there is common picture communication system; a conference was held with the school to coordinate behavioral interventions for self-injurious behavior). This coordination must take place directly between the ABA provider and any other service providers, and not through the parents

h. If functional progress is not occurring (i.e. one or two consecutive ITP's where patient is not meeting majority of goals and not making functional progress towards increased participation in home, school, or community activities and/or is not less of a safety risk to self or others) and there is not a reasonable expectation of further progress, then continuation of ABA services is not considered to be medically necessary

11. Every 12 months, standardized (norm-referenced) developmental assessment should be re-administered to assess whether patient continues to be making functional and measurable progress. The provider is to use the same instrument over time as much as possible so scores can be compared over time to measure progress.
12. The following are not considered to be medically necessary ABA services:
    a. More than one program manager/lead behavioral therapist for a member/identified patient at any one time.
    b. More than one agency/organization providing ABA services for a member/identified patient at any one time.
    c. If the school has determined that a child is eligible to receive services under an IEP which would overlap with ABA services and the school services are declined or discontinued by the parent.
    d. Activities and therapy modalities that do not constitute application of applied behavioral analysis techniques for treatment of autism. Examples include (but not limited to):
        i. Taking the member/identified patient to appointments or activities outside of the home (e.g. recreational activities, eating out, shopping, play activities, medical appointments), except when the member/identified patient has demonstrated a pattern of significant behavioral difficulties during such specific activities
        ii. Assisting the member/identified patient with academic work or functioning as a tutor, educational or other aide for the member/identified patient in school
        iii. Provision of services that are part of an IEP and therefore should be provided by school personnel, or other services that schools are obligated to provide
        iv. Doing house work or chores, or assisting the member/identified patient with house work or chores, except when the member has demonstrated a pattern of significant behavioral difficulties during specific house work or chores, or acquiring the skills to do specific house work or chores is part of the ABA treatment plan for the member/identified patient
        v. travel time
        vi. residing in the member's home and functioning as live-in help (e.g. in an au-pair role)

13. All ABA visits with the patient and/or family should be documented. Documentation should include:
    a. Who was present at the visit?
    b. Duration of the visit
    c. What was the targeted behavior during the visit?
    d. What was the procedure/activity/intervention during visit?
    e. What was the response to procedure/activity/intervention?
    f. Intervention format (individual, group, supervision, parent training)
    g. Graphical or numerical data to track progress/participation
    h. Signature title, credentials of person completing documentation
    i. Include targeted behavior, interventions, response, modifications in techniques and plan for next visit with behavior tracking sheets that record and graph data collected for each visit

ABA Provider Qualifications and Procedure Codes

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

a. At a minimum, the lead behavioral therapist, providing treatment and clinical supervision of treatment program must demonstrate that she/he is a board certified behavior analyst (BCBA) or must demonstrate that the she/he has at least 240 hours of coursework related to behavior analysis and/or 750 hours of supervised experience or 2 years of practical experience in designing and implementing comprehensive behavioral analytic therapies for children with autism; ***and***
b. ***Either***:

i. Individually satisfy **ALL of the following** requirements:
    1. Be a licensed health provider under Title 18, Revised Code of Washington, including but not limited to: speech therapist, occupational therapist, psychologist, pediatrician, neurologist, psychiatrist, mental health counselor, social worker; and
    2. Be licensed to practice independently; and
    3. Be credentialed and contracted by the Plan; ***or***
ii. Be employed by a Healthcare Delivery Organization that meets **All of the following** requirements:
    1. Be a hospital, mental health facility, home health agency or in-home agency licensed to provide home health services, or other mental health agency licensed by the Washington Department of Health; ***or*** a community mental health agency or home health agency licensed by the Washington Department of Social and Health Services; and
    2. Be credentialed and contracted by the Plan.

c. Clinical supervision for unlicensed staff providing services must be provided by a lead behavioral therapist as indicated above. Such supervision must:
    i. Include bimonthly (once every 60 days) approval and review of the ITP and case review of every member receiving clinical health services; and
    ii. Include at least one hour of on-site supervision, with on-site observation for at least one hour for every 40 hours of service to the member.

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

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

97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes.
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes.
97153 (with HO modifier)	Adaptive behavior treatment by protocol, administered by physician or other qualified health professional, face-to-face with one patient.

Revision History	Description
07/06/2021	MPC approved to adopt updates to clinical criteria for Non-Medicare members, with the exception of Microsoft, as there is separately maintained criteria for Microsoft members. Revisions made to clarify requirements, and a new requirement was added for two or more developmental and behavioral assessments used to measure gaps in functioning instead of one. Updated applicable coding to exclude H2017, 0362T, and 0373T. Requires 60-day notice, effective date October 1, 2021.