INLAND EMPIRE HEALTH PLAN

IEHP UM Subcommittee Approved Authorization Guidelines
Behavioral Health Treatment
Applied Behavior Analysis
For Qualified Autism Service Providers

Policy:
IEHP covers Behavioral Health Treatment for Medi Cal Members with Autism under the age of 21 years old. Applied Behavior Analysis, a covered benefit, is an evidence-based treatment under Behavioral Health Treatment. This policy will serve as a treatment guideline for authorizing the frequency, intensity, and duration of Applied Behavior Analysis for IEHP eligible Members.

CPT Codes Covered:

CPT Code	Outpatient Service Description
H0031	Mental Health Assessment, by Non-Physician
H2019	Therapeutic Behavioral Services, per 15 minutes
H0032	Mental Health Service Plan Development by Non-Physician
H0032-HO	Mental Health Service Plan Development by Non-Physician (Master's Degree Level)
H0032-HP	Mental Health Service Plan Development by Non-Physician (Doctoral level)
S5111	Home Care Training, Family; Per Session
H2014	Skills Training and Development

Background:

California Senate Bill 946

Senate Bill 946 went into effect July 1, 2012, requiring health care service plan contracts and health insurance policies to provide coverage for Behavioral Health Treatment (BHT) for individuals with autism or other pervasive developmental disorders (PDD). The bill did not apply to health care plans that do not provide mental or behavioral health services, or to Medi-Cal programs.

Centers for Medicare and Medicaid Services (CMS)

On July 7, 2014, the Centers for Medicare and Medicaid Services (CMS) released guidance regarding the coverage of Behavioral Health Treatment services pursuant to Section 1905(a)(4)(B) of the Social Security Act (SSA) for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT).

- BHT Services are a covered Medi-Cal benefit pursuant to the Welfare and Institutions Code Section 14132.56. Behavioral health treatment services are evidence-based treatments that are proven to be effective in the treatment of Autism Spectrum Disorder (ASD). BHT services teach skills through the use of behavioral observation and reinforcement, or through prompting to teach each step of a targeted behavior (California Department of Health Care Services 10, 11).
- BHT services are administered by a California State Plan CMS approved Provider as defined by Health and Safety Code Section 1374.73(c) (3), in conjunction with an approved behavioral health treatment plan, and services must meet medical necessity as defined by Welfare and Institutions Code Section 1432(v).

Diagnosis of Autism Spectrum Disorder

In the *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition* (DSM-5™) autism spectrum disorder is classified as a neurodevelopmental disorder, encompassing the DSM-IV autistic disorder, Asperger's disorder, childhood disintegrative disorder and pervasive developmental disorder, not otherwise specified. Individuals previously diagnosed with either of these diagnoses may now meet the criteria for ASD. Those with deficits in social communication whose symptoms do not meet criteria for ASD should be evaluated for social communication disorder (American Psychiatric Association, 2013).

DSM-5 criteria for ASD include:

1) Impairment in social communication and interaction, persistent and across multiple contexts, and
2) Repetitive, restricted patterns of behavior, activities or interests.

A severity scale must be recorded for each domain. Unlike the requirement in DSM-IV that onset must occur before age 3 years, the DSM-5 requires that individuals show symptoms that limit or impair everyday functioning in the early developmental period, encouraging earlier diagnosis of ASD. If ASD is accompanied by intellectual impairment, language impairment, catatonia or known medical, genetic or environmental factors, the diagnosis should specify

"associated with a known medical/genetic or environmental/acquired condition" (American Psychiatric Association, 2013).

Severity levels for autism spectrum disorder as defined by the new DSM-5 criteria:

Severity Level	Social Communication	Restricted, Repetitive Behaviors
Level 3 **(Severe)** **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 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 interferes with functioning in all spheres. Great distress/difficulty changing focus or action.
Level 2 **(Moderate)** **Requiring SUBSTANTIAL Support**	Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and how 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 and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.
Level 1 **(Mild)** **Requiring Support**	Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful response 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 communication 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 contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

Comorbidity

In a recent clinical synthesis, authors reported common psychiatric disorders and medical disorders for individuals with ASD as follows (Yu et al., 2016):

Comorbid Psychiatric Disorders:

- Intellectual disability (ID) – 20 percent to 53 percent of individuals with ASD
- Psychiatric disorders, e.g., attention-deficit hyperactivity disorder (ADHD), anxiety disorders, obsessive-compulsive disorder (OCD), depression and schizophrenia – approximately 70 percent of individuals with ASD
- Two or more psychiatric disorders – Nearly 40 percent of individuals with ASD
- Anxiety spectrum disorders – most common psychiatric condition comorbid with ASD (may be byproduct of core symptoms instead of comorbid condition)
- Obsessive Compulsive Disorder – 44 percent of individuals with ASD
- Catatonia – highest risk in adolescence.

Comorbid Medical Disorders:

- Seizure disorder – most common comorbid medical illness – 11 percent to 39 percent of individuals with ASD; onset before age 5 years and adolescence
- Gastrointestinal problems – commonly observed in patients with ASD (constipation and diarrhea)
- Sleep disturbance – underlying etiology or secondary to psychiatric illnesses.

A. Behavioral Health Treatment (BHT)

1. Behavior Health Treatment Service Definition:

BHT services are evidence-based treatments that develop or restore, to the maximum extent practicable, the functioning of an individual with autism spectrum disorder (ASD). BHT services teach skills through the use of behavioral observation and reinforcement, or through prompting to teach each step of a targeted behavior. BHT services, including Applied Behavior Analysis (ABA) and other evidence-based interventions based on reliable evidence and are not experimental. Examples of evidence based BHT services include behavioral interventions, cognitive behavioral intervention package, comprehensive behavioral treatment, language training, modeling, natural teaching strategies, parent/guardian training, peer training package, pivotal response training, schedules, scripting, self-management, social skills package, and story-based intervention (National Autism Center, 23).

a. **Applied Behavior Analysis (ABA)**: ABA is the science in which the principles of the analysis of behavior are applied systematically to improve socially significant behavior and experimentation is used to identify the variable responsible for behavior change (Cooper, Heron, & Heward, 2007). Applied Behavior Analysis designs, implements, and evaluates environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior. ABA is a behavior intervention model based on reliable evidence based practices focusing on targeted skills in all areas of development.

- **Functional Behavior Assessment (FBA):** FBA is an evaluation method of gathering information about problem behaviors. The underlying theory of FBA is that most problem behaviors serve some type of an adaptive function reinforced by consequences. The (FBA) is designed to help ABA professionals uncover the function of behavior which then guides the development and selection of appropriate treatment. Once the function of a behavior is understood, through the assessment procedures (e.g., clinical interview, record review, indirect rating scales, structured observations and functional analysis) the Qualified Autism Service Provider (QASP) will create intervention strategies that include teaching replacement behaviors that serve the same or similar functions as the target behavior as well as developing strategies to decrease the maladaptive behaviors.

  The goal of the Functional Behavior Assessment is to evaluate socially significant behaviors frequently targeted include addressing underlying issues that impair social skills, communication, adaptive living skills, eating and food preparation, toileting, dressing, personal self-care, domestic skills, time and punctuality,

money and value, home and community orientation and work skills. The Functional Behavior Assessment will develop a treatment plan to increase appropriate replacement behaviors, teaching new skills, maintaining selected behaviors, generalizing or transferring selected behaviors, restricting or narrowing conditions under which interfering behaviors occur, reducing interfering behaviors, and parental skill development and the application of those skills in natural settings.

According to the Behavior Analyst Certification Board's Practice Guidelines for Healthcare Funders and Managers (2nd ed.) for Applied Behavior Analysis Treatment of Autism Spectrum Disorder, two treatment model recommendations exist:

- **Comprehensive ABA Treatment:**

Comprehensive ABA refers to treatment of multiple affected developmental domains, such as adaptive and self-care skills, attending and social referencing, cognitive functioning, community participation, coping and tolerance skills, emotional development, family relationships, language and communication, play and leisure skills, pre-academic skills, reduction of interfering or inappropriate behaviors, safety skills, self-advocacy and independence, self-management, social relationships, and vocational skills (BACB, 2014).

There are different types of comprehensive treatment; one example is early intensive behavioral intervention (EIBI) where the overarching goal is to close the gap between the client's level of functioning and that of typically developing peers. These programs tend to range from 30-40 hours of treatment per week (plus direct and indirect supervision and caregiver training). Initially, this treatment model typically involves 1:1 staffing and gradually includes small-group formats as appropriate (BACB, 2014).

Training family members and other caregivers to manage problem behavior and to interact with the individual with ASD in a therapeutic manner is a critical component of this treatment model.

According to the California Association for Behavior Analysis (2011), Children aged 3 through 8 with a diagnosis of ASD are appropriate for comprehensive intensive ABA autism treatment, and there is extensive research that supports intensive comprehensive ABA programs for children up to 8 years of age has having made significant gains in IQ and adaptive behavior scores (CALABA, 2011).

According to Practice Guidelines for Healthcare Funders and Managers, Comprehensive ABA Treatment may also be appropriate for older individuals diagnosed with ASD, particularly if they engage in severe or dangerous behaviors across environments (BACB, 2014).

- **Focused ABA Treatment:**

Focused ABA treatment involves increasing socially appropriate behavior (e.g., increasing social initiations) or reducing problem behavior (e.g., aggression) as the primary target. Even when reduction of problem behavior is the primary goal, it is critical to also target increases in appropriate alternative behavior, because the absence of appropriate behavior is often the precursor to serious behavior disorders.

- Examples of key functional skills include, but are not limited to, establishing instruction-following, social communication skills, compliance with medical and dental procedures, sleep hygiene, self-care skills, safety skills, and independent leisure skills (e.g., appropriate participation in family and community activities).
- Examples of severe problem behaviors requiring focused intervention include, but are not limited to, self-injury, aggression, threats, pica, elopement, feeding disorders, stereotypic motor or vocal behavior, property destruction, noncompliance and disruptive behavior, or dysfunctional social behavior.

Individuals who need to acquire skills (e.g., communication, tolerating change in environments and activities, self-help, social skills) are also appropriate for Focused ABA.

Additionally, focused ABA plans are appropriate for individuals who need treatment only for a limited number of key functional skills or have such acute problem behavior that its treatment should be the priority.

b. **Social Skills Training**:
Social skills training refers to small group instruction by licensed and certified practitioners who teach a wide range of skills and abilities (e.g., appropriate eye contact, using gestures, understand body language, reciprocating information, initiating or ending an interaction, self manage behaviors, coping strategies, establish and build friendships, understand sarcasm) to individuals on the autism spectrum. Social skills are taught implementing principles of applied behavior analysis in addition to research based teaching curriculums (e.g., Social Thinking, PEERS, CIRCLES).

2. Behavioral Health Treatment Eligibility Criteria

BHT is a coverage benefit under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provision of Medi-Cal.

IEHP Members are eligible to receive Behavioral Health Treatment services if all the following items are met:

- Be under 21 years of age; and

- Have a diagnosis of ASD based upon completion of a comprehensive diagnostic evaluation (CDE); for individuals under three years of age, a rule out or provisional diagnosis is acceptable to receive BHT services;
- Have a recommendation from a licensed physician and surgeon or a licensed psychologist that evidence-based BHT services are medically necessary; and
- Be medically stable; and
- Be without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID).

a. **BHT Services from birth to 21 years of age:** Behavioral Health Treatment is provided up until the Member's 21st birthday. All Members currently in behavioral health treatment or Members referred for behavioral health treatment who meet all eligibility criteria and are within 6-months of the Member's 21st birthday, the health plan will generate an authorization effective until the day prior to the Member's 21st birthday.

b. **Comprehensive Diagnostic Evaluation (CDE):** Members are referred to IEHP for an Autism Evaluation by a licensed physician and surgeon or a licensed psychologist. According to the All Plan Letter (15-025) a Comprehensive Diagnostic Evaluation must meet all the below criteria:
   - Comprehensive unclothed medical examination (by the primary care physician/pediatrician as required by EPSDT); and
   - A parent/guardian interview; and
   - Direct play observation; and
   - Review of relevant medical, psychological, and/or school records; and
   - Cognitive/developmental assessment; and
   - Measure of adaptive functioning; and
   - Language assessment (by a speech language pathologist); and
   - Sensory evaluation (by and occupational therapist); and
   - If indicated, neurological and/or genetic assessment to rule out biological issues (by a developmental pediatrician, pediatric neurologist, and/or geneticist).

   Members who are referred for Behavioral Health Treatment by Licensed Physician or Licensed Psychologist who lack supporting clinical documentation (e.g., Comprehensive Evaluation report) to confirm an Autism diagnosis or evaluations submitted to IEHP that do not meet the outlined CDE criteria, will result in a referral for Comprehensive Diagnostic Evaluation with network provider.

   Exclusionary Documentation: The below documentations are not accepted to confirm a medical diagnosis of autism and meet medical necessity:

- Regional Center Individual Program Plan (IPP)
- Regional Center Client Development Evaluation Report (CDER)
- Early Start Progress Report
- Applied Behavior Analysis Functional Behavior Assessment/ Progress Report
- School District Individual Education Plan
- School Psychologist Psycho-Education Evaluation
- Autism Diagnosis Written on a Prescription
- Physician Progress Notes/Clinic Notes Referencing that Member has Autism
- Referral Forms with Primary/Secondary Diagnosis listed as Autism
- Occupational Therapy Evaluation/ Progress Report
- Speech and Language Therapy Evaluation/ Progress Report

Exceptions to Criteria: The below information are exceptions to a Member requiring a CDE level evaluation of Autism.

- IEHP will accept Psycho-Diagnostic evaluations and confirmed autism diagnosis on a case by case basis following clinical review of the supporting medical documentation.

c. **Recommendation for Behavioral Health Treatment:** Members need to receive a referral and recommendation from a licensed physician and surgeon or a licensed psychologist that evidence-based BHT services are medically necessary.

d. **Medically Stable:** The Member should be medically stable in order to benefit from medically necessary Behavioral Health Treatment. Members with chronic mental illness, severe medical issues which cause concern for medical stability should be evaluated and cleared by a licensed medical professional to actively participate in Behavioral Health Treatment.

e. **Without 24-hour Medical/Nursing Monitoring:** The Member should be without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID).

According to California Department of Developmental Services, Intermediate Care Facilities (ICF) are health facilities licensed by the Licensing and Certification Division of the California Department of Public Health (CDPH) to provide 24-hour-per-day services. There are three types of ICFs, which all provide services to Californians with developmental disabilities:

- **ICF/DD** (Intermediate care facility/developmentally disabled) is a facility that provides 24-hour personal care, habilitation, developmental, and supportive health services to developmentally disabled clients whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services.
- **ICF/DD-H** (Intermediate care facility/developmentally disabled-habilitative) is a facility with a capacity of 4 to 15 beds that provides 24-hour personal care, habilitation, developmental, and supportive health services to 15 or fewer

developmentally disabled persons who have intermittent recurring needs for nursing services, but have been certified by a physician and surgeon as not requiring availability of continuous skilled nursing care.

- **ICF/DD-N** (Intermediate care facility/developmentally disabled-nursing) is a facility with a capacity of 4 to 15 beds that provides 24-hour personal care, developmental services, and nursing supervision for developmentally disabled persons who have intermittent recurring needs for skilled nursing care but have been certified by a physician and surgeon as not requiring continuous skilled nursing care. The facility shall serve medically fragile persons who have developmental disabilities or demonstrate significant developmental delay that may lead to a developmental disability if not treated.

3. Comparative Studies on Effective Implementation of Applied Behavior Analysis

Behavioral Treatment and Normal Educational and Intellectual Functioning in Young Autistic Children-

In 1987, Dr. Lovaas, at University of California, Los Angeles (UCLA) studied the effects of using Applied Behavior Analysis with children diagnosed with Autism. In this landmark study, Lovaas found the nearly half of the children who received 40 hours per week of ABA therapy were eventually able to complete normal first-grade classes and acquire a normal range of IQ, while none of the children in the control group who received 10 hours per week were able to do the same, and were placed in self-contained classrooms for individuals with Autism.

Long-term outcome for children with autism who received early intensive behavioral treatment-

In 1993, Lovaas' and colleagues conducted a follow-up study to measure the long-term outcome for children with autism who received early intensive behavioral treatment. According to findings the children who received early intensive behavioral treatment maintained their skills in early adolescence and were expected to succeed in life without costly special education and residential services.

Cost-Benefit Analysis of Intensive, Early Behavioral Intervention-

Jacobson, Mulick, and Green 1998 study demonstrated that providing behavioral treatment to all children with autism for three years, delivered between the ages of 2 to 6 years, would save approximately $200,000 per child for ages 3-22 years and up to $1,000,000 per child for ages 3-55 years. The savings per child even takes into account that some children will not benefit at all from behavioral treatment and some will only make modest gains.

Intensive Behavioral Treatment for Children with Autism: Four-Year Outcome and

Predictors-

In 2005, Dr. Sallows replicated the 1987 Lovaas study and found that 48% of all children showed rapid learning, achieved average post treatment scores, and at age 7, were succeeding in regular education classrooms. These results are consistent with those reported by Lovaas and colleagues (Lovaas, 1987; McEachin, Smith, & Lovaas, 1993).

Early Intensive Behavioral Treatment: Replication of the UCLA Model in a Community Setting-

In 2006, this study conducted a 3-year prospective outcome study that compared 2 groups: 21 children who received 35 to 40 hours per week of Early Intensive Behavior Therapy from a community agency that replicated Lovaas' model and 21 age- and IQ-matched children in special education classes at local public schools. According to the findings children who received behavioral treatment scored significantly higher in IQ and adaptive behavior scores than the comparison group. Further, 29% (6 of 21) children were fully included in regular education without assistance and another 52% (11 of 21) were included with support. This compares to only 5% (1 of 21) children in the control group who were placed in regular education (Cohen, Howard, Amerine-Dickens, Mila, Smith, Tristram, 2006).

4. Professional Societies National Acceptance of Applied Behavior Analysis

National Insitiute of Mental Health (NIMH)

The mission of the National Insitiute of Mental Health is to further the understanding and treatment of mentla illness through clinical and basci research. Utilizing the evidence and results from their research, their goal is to create a path toward precention, revcovery, and cure for mental illness.

National Insitiute of Mental Health recognizes that apllied behavior analysis have become widely accepted as an effective treatrment for individuals with autism. The goal of behavioral management is to reinforce desirable behaviors and reduce undesirable ones. Effecitve programs will teach early communication and social interaction skills.

American Psychological Association (APA)

The American Psychological Association is a scientific and professional organization that represents psychology in the United States, with more than 54,000 members; it is the largest association of psychologists worldwide. The American Psychological Association's mission is to advance the creation, communication and application of psychological knowledge to benefit society and improve people's lives.

The American Psychological Association believes that medications on their own rarely improve behavior, so behavioral interventions are crucial. The APA concurs with the findings of psychologist Ivar Lovaas, Ph.D, and his work beginning in the 1960s with ABA therapy for autism and the landmark 1987 study, where Dr. Lovaas found that half

of the children who received 40 hours per week of ABA therapy were eventually able to complete normal first-grade classes, while none of the children who received the therapy of only 10 hours per week were able to do the same.

National Insitiute of Child Health and Human Development (NICHD)
The National Insitiute of Child Health and Human Development was initally established to investigate the broad aspects of human development as a means of understanding developmental siabilities, and now conducts and supports research on all stages of human development, from preconception to adulthood.

The National Insitiute of Child Health and Human Development concludes that behavior mangagemetn therapy works to reinforce wanted behaviors and reduce unwanted behaviors. Behavioral Therapy is often based on Applied Behavior Analysis. National Insitiute of Child Health and Human Development believes that ABA therapy is a way to help minimize the symptoms of autism and to maximize learning.

The Kennedy Krieger Institiute
The Kennedy Krieger Institiute is internationally recongized hospital, research, and teraching insitituion specialiing in neuobehavioral health services.

The treatment of autistic patients at Kennedy Krieger Institiute emphasizes applied behavior analsysis (ABA). The insutute's offical position is that ABA is a form of therapy that has been shown to reduce problem behavior and increase appropriate skills for individuals with intellectuatl disabilities. Their research, along with the large body of studies into ABA treatment, provides empirical evicence indicateding that procedures development using ABA-based principles are effective at assessing and treating a variety of maladaptive behavioral engaged in by individuals with a variety of dianoses, including autism, and intellectuatl and developmental disabilities.

5. Medical Necessity Treatment Guidelines for Applied Behavior Analysis:
IEHP treatment guidelines provide a framework for recommendations for the treatment intensity and frequency based on age, ASD core deficits, developmental needs, ASD severity level, and the individual needs of the member and family.

Functional Behavior Assessment (FBA) Guidelines
When a Member is referred to behavioral health for ABA therapy and has a confirmed Autism diagnosis, the Member is authorized for a Functional Behavior Assessment with a network Provider.

- IEHP will authorize a maximum of ten (10) hours for a functional behavior assessment.
- FBA authorizations are effective for a 60-day period.
- Providers must use the approved IEHP FBA treatment plan template. (See ***Appendix A*** *for a sample form.)*

The FBA Should Include:

In order for IEHP to authorize initial ABA Treatment all of the following criteria must be met:

1. The FBA must contain the Member's information (e.g., name, DOB, IEHP Identification number, home address, phone number, parent/guardian name, and spoken language);
2. Referral information (e.g., referral date, presenting concerns);
3. Background Information (e.g., family living, school, health and medical, services and activities, intervention history, and availability), which will require a review of the Member's medical, psychiatric, educational records;
4. A structured clinical interview with parent/guardian;
5. Administration of validated developmental and adaptive skills assessment (e.g., ABAS, Vineland, VB-MAPP or AFLS) to establish baseline functioning;
6. Administration of Preference Assessment (e.g., free operant, single stimulus, paired stimulus, multiple stimulus with replacement, multiple stimulus without replacement, reinforcement assessment, RAISD, or checklists);
7. A minimum of 2 Member observations across all relevant settings (e.g., home, school and community);
8. An evaluation of the purpose of maladaptive behaviors using a validated assessment tool (e.g., QABF, FAST, MAS);
9. Structured data collection of the identified behaviors and analysis of antecedents and consequences;
10. Target Behaviors that warrant clinical attention should be operationally defined, have a clear onset/offset, course of behavior, history and recent changes, baseline levels and severity. Each behavior will need a statement on the social significance.
11. A detailed description of behavior reduction goals with clear definition, antecedent, baseline, and mastery criteria for needed skills development;
12. A detailed description of replacement behavior and skill acquisition goal selection based on reported behaviors and developmental evaluation scores;
13. Caregiver training goals and a plan to provide necessary support and training to caregivers as well as a plan to evaluate their acquisition of these skills;
14. A Behavior Plan that includes Ecological/Antecedent Strategies, Reactive/Consequence Strategies, Teaching Procedures for Replacement Behaviors;
15. A detailed proposal for the intensity and duration of services, as well as the locations where those services; and
16. A clear plan with objective milestones for the systematic reduction of care and the criteria for discharge from services.

Initial Treatment Recommendation Guidelines

Comprehensive ABA Treatment:

National Behavior Analyst Certification Board (BACB, 2014) - Comprehensive ABA Treatment **typically ranges from 30 to 40 total hours weekly**.

However, IEHP will approve the intensity, frequency, and duration of Comprehensive ABA Treatment based upon the table below.

Providers must complete and provide clinical documentation of the American Psychiatric Association's (2013) Clinician-Rated Severity of Autism Spectrum and Social Communication Disorders (See ***Appendix B*** *for a sample form.).*

California Association for Behavior Analysis (2011) - children aged 3 through 8 with a diagnosis of ASD are appropriate for intensive comprehensive intensive ABA treatment. This age range assumes that the children started treatment before the age of 5, and that services are fading in intensity before age 8.

If a member over the age of 8 and did not receive intensive comprehensive intensive ABA treatment, please reference the **Exceptions to Recommendation Treatment Guidelines.**

Comprehensive ABA Treatment				
Age	**Hours**	**Level 1**	**Level 2**	**Level 3**
0 - 8 years	**Hours per week**	**< 15**	**< 25**	**< 40**

Behavior Intervention (Focused ABA Treatment):
The health plan will approve the intensity, frequency, and duration of Focused ABA Treatment based upon the table below.

California Association for Behavior Analysis (2011) - Behavior Intervention (Focused ABA Treatment) service **may range up to 20 hours of intensive services** combined per week. The weekly duration of services is outlined below by the level of impairment.

National Behavior Analyst Certification Board (BACB, 2014) - Focused ABA generally ranges from **10-25 hours per week** of direct treatment (plus direct and indirect supervision and caregiver training). However, certain programs for severe destructive behavior **may require more than 25 hours per week** of direct therapy (for example, day treatment or inpatient program for severe self-injurious behavior).

Members will meet medical necessity for the Behavior Intervention (Focused ABA Treatment) if they meet one or more of the following:

1. Display behaviors that may threaten the health or safety of him/herself or others (e.g., aggression, self-injury, property destruction);
2. Engage in behaviors that may be a barrier to his/her ability to remain in the least restrictive setting, and/or limit his/her ability to participate in family and community life (e.g., aggression, self-injury, noncompliance); and/or
3. Have failed to acquire developmentally appropriate adaptive or functional skills (e.g., toileting, dressing, feeding) that are fundamental to attain social inclusion and increased independence.

Behavior Intervention (Focused ABA Treatment)				
Age	**Hours**	**Level 1**	**Level 2**	**Level 3**
0 – 8 years	**Hours per week**	**< 10**	**< 15**	**< 25**
8 - 11 years	**Hours per week**	**< 10**	**< 15**	**< 25**
12 - 18 years	**Hours per week**	**< 10**	**< 15**	**< 25**
18 - 21 years	**Hours per week**	**< 10**	**< 15**	**< 25**

Limitations and Exclusionary Criteria to Recommended Treatment Guidelines:

The following do not meet medical necessity for ABA Treatment and will therefore, not be authorized by IEHP:

- ABA services that duplicate or replicate services received in the Member's primary academic educational setting, outlined within the Individualized Education Plan (IEP), or are purely academic in nature. This includes providing direct ABA therapy in the Member's school for educational purposes.
- ABA Services, supplies or procedures performed in a non-conventional setting including, but not limited to, resorts, spas and camps.
- ABA services whose sole purpose is vocationally (e.g., employment related, job training, supportive employment) or recreationally-based (e.g., soccer, baseball, karate, gymnastics, horseback riding).
- ABA Services that are not evidence-based practices used in the treatment of ASD.

- ABA Services for the purposes of providing or coordinating respite and/or day care. Direct ABA services will not be authorized in order for a member to remain in a daycare facility.
- ABA Service in hospital settings when the Member has been admitted.
    - ABA will be authorized to assist the Member with scheduled medical appointments.
- IEHP will not authorize ABA Services for Members placed in a residential facility.

Exceptions to Recommended Treatment Guidelines:

IEHP may approve more than the outlined hours per week for a Member if at least one of the following is true:

1. Member needs crisis intervention; and/or
2. Member is at risk of out-of-home placement due to challenging behaviors; and/or
3. Member needs an intensive boost of intervention for a short period of time based on a developmental or environmental transition or change in circumstances; and/or
4. Person did not have access to Comprehensive ABA Treatment early in life; and/or
5. Qualified Autism Service Provider recommends more than the outlined hours per week and documents rationale and medical necessity for such intensity of treatment.

Supervision Guidelines for Comprehensive and Focused Treatment:

Up to 2 hours of supervision per 10 hours of direct treatment- According to the Behavior Analyst Certification Board (2014), the standard of care for ABA treatment programs supervision is 2 hours of supervision for every 10 hours of direct treatment.

Supervision ratios are consistent with two and three tier treatment models, the cumulative recommendation hours for supervision shall not exceed the about BACB standard level of care (2 hours of supervision for every 10 hours direct treatment).

Enhanced Supervision is available due to situational crises, transitions, the need for extensive analysis of a refractory problem behavior, or other factors. Provider needs to provide clinical rationale for Enhanced Supervision.

Parent Education Guidelines for Comprehensive and Focused Treatment:

Caregivers include not only parents, but also extended family and household employees who care for the child on a regular basis. Parent education and training is an essential component of ABA treatment, parents must be involved in training in behavioral techniques so that they can implement the intervention plan outside of treatment sessions and provide additional hours of intervention. Training of caregivers was a critical part of the control group (children who received 40+ hours per week of ABA) in the 1987, Lovaas study at UCLA. Parents within the Lovaas study worked as part of the treatment team and were extensively trained in all treatment procedures so that ABA treatment

could take place for almost all of the subjects' waking hours, 365 days a year, for the duration of the study.

Social Skills Guidelines for Treatment:

5 hours for Social Skills Assessment - Members who are receiving ABA treatment from a provider who does not offer social skills in a group format, will be authorized a maximum of ten (5) hours for an assessment to evaluate the Member's need for social skills and to develop a social skills treatment plan and goals for the Member.

ABA Treatment Continued Care (Comprehensive and Focused):

The health plan will reauthorize Continued ABA Treatment upon receipt of 6-month progress report from the Provider when all the following are met:

- The Member is still eligible to receive Behavioral Health Treatment services based upon the eligibility criteria; and
- The Provider reports progress on the IEHP approved Progress Report Template (See ***Appendix C*** *for a sample form.*); and
- The Provider has completed the Clinician-Rated Severity of Autism Spectrum and Social Communication Disorder Level of Impairment within the previous 12-month period (See ***Appendix B*** *for a sample form.)* ; and
- The Member shows improvement from baseline levels the areas of skill deficits (e.g., communication, social skills, and self-help) and problematic behaviors targeted in the treatment plan. The Member needs to make a minimum of 25% progress in skill deficits and problematic behavior goals; and
- Provider makes adjustments to the treatment plan based upon data:
    - New skill acquisition goals and behavior goals are add to the treatment plan to replace goals that have been met.
    - Modifications to the behavior intervention plan when a Member is not progressing.

The IEHP approved 6-Month Progress Report Template Should Include:

1. The Member's information (e.g., name, DOB, IEHP Identification number, home address, phone number, parent/guardian name, and spoken language);
2. Updated background Information (e.g., family living, school, health and medical, services and activities);
3. Validated developmental and adaptive skills assessment (e.g., ABAS, VB-MAPP or AFLS) should be administered every 6 months, while the Vineland is administered every 12 months to evaluate progress from baseline functioning, and reflected in the report;
4. Progress reported on each program goal, progress is depicted graphically and include a summary narrative of mastered targets, current targets in acquisition;
5. Progress report of parent goals; and
6. Clinical Recommendation for continued treatment.

Criteria for Discharge from Care:

A Member is discharge from behavioral health treatment when one of the following occurs:

1. Member no longer meets the eligibility coverage criteria for Behavioral Health Treatment; and/or
2. Parents/Guardian have refused, withdrew consent, and/or are in non-compliance of the treatment recommendations; and/or
3. Non-conserved Adult Member refuses treatment recommendations; and/or
4. Member is unlikely to continue to benefit or maintain gains from continued ABA treatment; and/or
5. ABA recommendations are on the basis of custodial care; treatment is provided primarily for maintain the Member's or anyone else's safety; and/or
6. Member shows improvement from baseline skills targeted within the skill deficits and problematic behaviors such that the goals are achieved or maximum benefit has been reached. This is outlined when the criteria has been met, treatment is recommended in order to maintenance skill and/or prevent regression of skill level.

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