# Clinical Policy: Autism Spectrum Disorder (ASD) Services

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Date of Last Revision: 03/24

Coding Implications
Revision Log

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

**Description**

This clinical policy outlines the utilization management of authorization requests for autism spectrum disorder (ASD) services within South Carolina Department of Health and Human Services (SCDHHS).[1]

Autism spectrum disorder (ASD) is a developmental disability that can cause significant social, communication, and behavioral challenges. "ASD is characterized by varying degrees of difficulty in social interaction, verbal and nonverbal communication, and the presence of repetitive behavior and/or restricted interests." The degree of impairment in functioning varies between each member/enrollee and therefore, treatment may vary in terms of intensity, duration, and complexity.[2]

Applied Behavior Analysis (ABA) focuses on the "analysis, design, implementation, and evaluation of social and other environmental modification to produce changes in behavior. ABA includes the use of "direct observation, measurement, and functional analysis of the relations between environment and behavior."[2]

**Policy/Criteria**

**I.** It is the policy of Absolute Total Care and Centene Advanced Behavioral Health that *applied behavioral analysis services* (ABA) are **medically necessary** when meeting all of the following:

A. Member/enrollee is ≤ 21 years of age;
B. Diagnosis meets one of the following:
   1. Previously established diagnosis is documented through a comprehensive psychological assessment/testing report including all the following:
      a. A behavioral observation;
      b. A caregiver clinical interview;
      c. Documentation of at least three of the following instruments to establish the ASD diagnosis, one of which must be an ASD-specific diagnostic tool:
         i. Autism Diagnostic Observation Schedule (ADOS);
         ii. A standardized measure of intelligence (e.g., WISC or WAIS, Stanford-Binet, Bayley Scales, etc.);
         iii. Autism Diagnostic Interview (ADI);
         iv. Behavior Assessment System for Children (BASC);
         v. Childhood Autism Rating Scale (CARS);
         vi. Gilliam Autism Rating Scale (GARS);
         vii. Vineland Adaptive Behavioral Scales (Vineland);
         viii. Assessment of Basic Language and Learning Skills (ABLLS-R);
         ix. Social Responsiveness Scale (SRS);
         x. Screening checklists (e.g., MCHAT, STAT, ASQ, etc.);

xi. Social Communication Questionnaire (SCQ);
xii. Other valid form of approved evidence-based standardized assessment measure;

d. The report includes all of the following information:
i. Member/enrollee's name and date of birth;
ii. Date of evaluation session(s) and date of the report;
iii. Psychiatric diagnosis from the current edition of the DSM;
iv. Referral question and/or reason for assessment;
v. Administered tests;
vi. Name of a certifying practitioner, to include professional title, signature, and date;

2. Member/enrollee is under the age of four years and psychological assessments reflect a presumptive diagnosis and document all of the following:
a. Observation of the member/enrollee's behavior in multiple settings;
b. Clinical interview with parents, guardians, and/or other significant individuals involved in the member/enrollee's care;
c. A licensed psychologist, school psychologist or developmental pediatrician must complete a comprehensive psychological assessment/testing report by the member/enrollee's fourth birthday, to confirm the ASD diagnosis;

3. Member/enrollee has an established ASD diagnosis based on the current edition of the Diagnostic and Statistical Manual of Mental Disorder (DSM), including severity level, and both of the following:
a. Diagnosis is confirmed by one of the following licensed health care practitioners, working within their scope of practice, who has provided a referral for Applied Behavioral Analysis (ABA) services:
i. Licensed Psychologist;
ii. Developmental Pediatrician;
iii. Licensed Psycho-Educational Specialist (LPES), certified by the South Carolina Department of Education;
b. The ASD diagnosis is certified through a *comprehensive psychological assessment/testing report* which includes all of the following:
i. A clinical interview with the member/enrollee and/or family members or guardians (as appropriate);
ii. A review of the presenting problems, symptoms and functional deficits, strengths, and history, including past psychological assessment reports and records;
iii. Behavior observation in one or more settings;
iv. Autism Diagnostic Observation Schedule (ADOS);
v. A standardized measure of intelligence (e.g., WISC or WAIS, Stanford-Binet, Bayley Scales, etc.);
vi. One or more of the following screening tools:
a) Autism Diagnostic Interview (ADI);
b) Behavior Assessment System for Children (BASC);
c) Childhood Autism Rating Scale (CARS);
d) Gilliam Autism Rating Scale (GARS);
e) Vineland Adaptive Behavioral Scales (Vineland);

f) Assessment of Basic Language and Learning Skills (ABLLS-R);
g) Social Responsiveness Scale (SRS);
h) Screening checklists (e.g., MCHAT, STAT, ASQ, etc.);
i) Social Communication Questionnaire (SCQ);
j) Other valid form of approved evidence-based standardized assessment measure;

vii. Member/enrollee's name and date of birth;
viii. Date of evaluation session(s) and date of the report;
ix. Psychiatric diagnosis from the current edition of the DSM;
x. Referral question and/or reason for assessment;
xi. Administered tests;
xii. Name of a certifying practitioner, to include professional title, signature, and date;
xiii. Medical history and medications;
xiv. Family history;
xv. Psychological and/or psychiatric treatment history including previous psychological assessment/testing reports, etc.;
xvi. Substance use history;
xvii. Member/enrollee and/or family strengths and support system;
xviii. History of exposure to physical abuse, sexual abuse, anti-social behavior, or other traumatic events;
xix. Recommendations for additional services, support, or treatment based on medical necessity criteria, including specific rehabilitative services (e.g., occupational therapy, speech therapy, etc.);

C. *Behavior identification assessment* is completed face to face with the member and caregiver(s), prior to the initiation of services, and includes documentation of all the following:
1. Administered by a Board-Certified Behavior Analyst (BCBA) or a Board-Certified Assistant Behavior Analyst (BCaBA);
2. Administration of standardized and non-standardized tests;
3. Detailed behavioral history including direct observation and caregiver interview;
4. Interpretation of test results to determine baseline levels of adaptive and maladaptive behaviors and functional behavior analysis;
5. Discussion of findings and recommendations with the primary guardian(s)/caregiver(s);
6. Assessments to include both of the following:
   a. Vineland Adaptive Behavior Scale;
   b. Two or more of the following:
      i. Pervasive Developmental Disorder Behavioral Inventory;
      ii. Social Responsiveness Scale;
      iii. Promoting the Emergence of Advanced Knowledge - Comprehensive Assessment;
      iv. Verbal Behavior Milestones Assessment and Placement Program
      v. Assessment of Functional Living Skills;
      vi. Essentials for Living;
      vii. Assessment of Basic Language and Learning Skills;

D. Request is for one of the following:
   1. *Initiation of ABA treatment* and all the following:
      a. A comprehensive psychological assessment/testing report is provided;
      b. The behavior identification assessment is provided;
      c. Individualized plan of care (IPOC) documents all the following and is completed no later than the 10th business day after the completion of the behavior assessment:
         i. Identification of the member/enrollee's strengths, needs, abilities and preferences;
         ii. Goals and objectives of treatment in alignment with the behavioral assessment and evaluation results;
         iii. An outline to address the needs of the member/enrollee, including but not limited to, the specific description of the recommended amount, type, frequency, setting, and duration of ASD treatment services;
         iv. Specific treatment activities or interventions;
         v. Amount and type of parent/caregiver participation, as applicable;
         vi. Date of each completed progress summary and annual re-development;
         vii. Signature, title, and date by the multidisciplinary team members including the parent and/or caregiver;
         viii. Plan for clinically appropriate coordination between the ASD network provider, the referring entity regarding treatment, and the member/enrollee's school, as applicable;
         ix. The ASD provider will submit the clinical service documentation to the referring entity describing the services rendered, outcomes achieved, and any recommendation for continued or additional services;
      d. Services are provided by one of the following practitioners:
         i. Board-Certified Behavior Analyst-Doctoral (BCBA-D);
         ii. Board-Certified Behavior Analyst (BCBA);
         iii. Board-Certified Assistant Behavior Analyst (BCaBA). Note: under the direct supervision of a BCBA;
         iv. Registered Behavior Technician (RBT) or Behavior Technician. Note: under the direct supervision of a BCBA;
      e. *Direct treatment services* include any of the following: Note: One hour of direct supervision is provided for every ten hours of therapy:
         i. Adaptive Behavior Treatment by Protocol, administered by a technician face-to-face with one member/enrollee under the direction of a BCBA or BCaBA;
         ii. Group Adaptive Behavior Treatment by Protocol, administered or performed by one of the following with two or more member/enrollees:
            a) Administered by a BCBA or BCaBA, utilizing a behavioral intervention protocol designed in advance by the BCBA or BCaBA;
            b) Performed by a RBT and administered by an RBT under the direction of a qualified healthcare professional, utilizing a behavioral intervention protocol designed in advance by the BCBA or BCaBA;

iii. Adaptive Behavior Treatment with Protocol Modification, administered by a BCBA or BCaBA face-to-face with a single member/enrollee to resolve one or more problems with the protocol;
iv. Family Adaptive Behavior Treatment Guidance, administered by a BCBA or BCaBA with guardian(s)/caregiver(s), without the presence of the member/enrollee, to identify behaviors and deficits and teach guardian(s)/caregiver(s) of one beneficiary to utilize treatment protocols designed to reduce maladaptive behaviors and/or skill deficits;

2. *Continuation of ABA treatment* and all the following:
   a. Criteria for *initiation of services* continues to be met;
   b. Progress summary includes all the following:
      i. Specific objective(s) from the IPOC that were a focus of treatment;
      ii. Specific treatment activities or interventions;
      iii. Identification of goals that have been met;
      iv. Cumulative graphs of goals and objectives demonstrating progress or areas of concern;
      v. Explanation of any delayed progress, to include barriers to progress, toward IPOC goals;
      vi. Explanation of any failure to provide the recommended services and their frequency;
      vii. Amount and type of parent/caregiver participation, as applicable to the member/enrollee;
      viii. Summary of the treatment plan for the upcoming treatment period, to tie into objectives and goals of the IPOC;
      ix. Addresses any dates of service not previously reported on in a prior progress summary;
      x. Signature, title, and date by the multidisciplinary team members including the parent and/or caregiver;
      xi. Documentation of clinically appropriate coordination between the ASD network provider, the referring entity regarding treatment, and the member/enrollee's school, as applicable;
      xii. The ASD provider has submitted to the referring entity clinical service documentation describing the services rendered, outcomes achieved, and any recommendation for continued or additional services;
      xiii. Completed no sooner than 30 days prior to the expiration of the previous authorization period and no later than the 10th day immediately following the last date of authorized treatment. Note: The due date for the progress summary report is based on the last date of the authorized treatment or final date of service;
   c. A new IPOC is developed every 12 months. Note: The original IPOC signature date stands as the date to be used for all subsequent reviews and reformulations.

**II.** It is the policy of Absolute Total Care and Centene Advanced Behavioral Health that when a covered benefit, transition of care from *applied behavioral analysis services* (ABA) services are medically necessary when meeting all the following:

A. Transition planning and discharge considerations are made with input from the entire care team and begin within three to six months prior to the first change in service;
B. Gradual step-down in services occurs over six months or longer;
C. A written plan contains all of the following:
    1. Specific details of monitoring and follow-up;
    2. Description of roles and responsibilities of all providers;
    3. Effective dates for behavioral targets that must be achieved prior to the next phase;
    4. Specified and coordinated with all providers, the member/enrollee and family members.

**III.** It is the policy of Absolute Total Care and Centene Advanced Behavioral Health that discharge from *applied behavioral analysis services* (ABA)services are medically necessary when meeting any of the following:

A. Level of functioning has significantly improved relative to standardized measures of behavior and ability;
B. Member/enrollee requests discharge (and is not imminently dangerous to self or others);
C. Member/enrollee requires a higher level of care (i.e., inpatient hospitalization or psychiatric residential treatment facility);
D. Member/enrollee has reached age 21.

**Background**

Autism Spectrum Disorder (ASD) can present with differing degrees of impairment in social and behavioral functions. Management of ASD is individualized according to age and specific needs. It requires a multidisciplinary lifespan approach using behavioral, developmental, and educational interventions to target the core symptoms of ASD with the objective of improving overall function. Intensive behavioral and educational interventions are the primary component of treatment programs for children and adolescents with ASD. Systematic reviews have shown that behavioral-based interventions and developmental models are most effective when provided early and intensively.[3] Routine development, behavioral and ASD screening are recommended when abnormalities are suspected in social interaction due to limited social communication skills and restricted, repetitive patterns of behavior, interest, and activities.[4]

In 2023, the Center for Disease Control and Prevention (CDC) released a new report from the Autism and Developmental Disabilities Monitoring (ADDM) network detailing prevalence rates, characteristics, and screening and diagnostic information. In this report the CDC noted an increase in the prevalence rate of 8-year-olds diagnosed with autism as 1 in 36 in 2020. The report highlights that for the first time, that percentage of Asian or Pacific Islander, Hispanic, and Black children identified with autism was higher than among 8-year-old White children. This shift reflects improved screening, awareness, and access to services among historically underserved groups. According to the CDC and Autism Society, the Covid-19 pandemic disrupted progress in the effort to improve early detection in children by the age of four. This has contributed to long wait list to receive timely screening and diagnosis, delaying the opportunity to connect to early intervention services.[5]

*South Carolina Department of Health and Human Services (SCDHHS)*[1]
Effective July 1, 2017, the South Carolina Department of Health, and Human Services (SCDHHS) elected to cover all medically necessary care for children with autism through age 21 as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit under the South Carolina Title XIX State Plan.

*Council of Autism Service providers (CASP)*[2]
The Council of Autism Service Providers (CASP) has developed guidelines and recommendations that reflect established research findings and best clinical practices. These guidelines focus on the use of ABA as a behavioral health treatment to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual with ASD. ABA includes the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. Services will fall into two treatment models Focused ABA and Comprehensive ABA.
The following are four core characteristics essential to the practice elements of ABA treatment:
1. An objective assessment and analysis of the member/enrollee's condition by observing how the environment affects the member/enrollee's behavior, as evidenced through appropriate data collection.
2. Importance given to understanding the context of the behavior and the behavior's value to the individual, the family, and the community.
3. Utilization of the principles and procedures of behavior analysis such that the member/enrollee's health, independence, and quality of life are improved.
4. Consistent, ongoing, objective assessment and data analysis to inform clinical decision-making.

*Center for Disease Control and Prevention (CDC)*[6]
The Children's Health Act of 2000 authorized the Centers for Disease Control and Prevention (CDC) to create the Autism and Developmental Disabilities Monitoring (ADDM) Network to track the number and characteristics of children with autism spectrum disorder (ASD) and other developmental disabilities in diverse communities throughout the United States.

*Autism Society of South Carolina*[7]
Autism Spectrum Disorder (ASD), hereafter referred to as Autism (which includes Asperger's Disorder and Pervasive Developmental Disorder – Not Otherwise Specified [PDD-NOS]), is a complex, lifelong developmental condition that typically appears during early childhood and can impact a person's social skills, communication, relationships, and self-regulation. It is defined by a certain set of behaviors and is often referred to as a "spectrum condition" that affects people differently and to varying degrees.

*American Academy of Pediatrics (AAP)*[8]
The APA recommends developmental screenings at 9, 18 and 24 months and screening for autism spectrum disorder (ASD) at ages 18 and 24 months, in addition to regular developmental surveillance. Toddlers and children should be referred for diagnostic evaluation when increased risk for developmental disorders (including ASD) is identified through screening/surveillance. Although symptoms of ASD are neurologically based, they manifest as behavioral characteristics

that present differently depending on age, language level, and cognitive abilities. Screening helps to determine if additional investigation is necessary.

*Autism Speaks*[9]
Autism Speaks references a three-step process used during ABA treatment (A: antecedent, B: behavior and C: consequence) which assists with understanding why a behavior happens and how different consequences can affect whether the behavior is likely to happen again:

1. An antecedent: this is what occurs right before the target behavior. It can be verbal, such as a command or request. It can also be physical, such a toy or object, or a light, sound, or something else in the environment. An antecedent may come from the environment, from another person, or be internal (such as a thought or feeling).
2. A resulting behavior: this is the person's response or lack of response to the antecedent. It can be an action, a verbal response, or something else.
3. A consequence: this is what comes directly after the behavior. It can include positive reinforcement of the desired behavior, or no reaction for incorrect/inappropriate responses.

*The Diagnostic and Statistical Manual of Mental Disorder, Fifth edition (DSM-5-TR)*[10]
The Diagnostic and Statistical Manual of Mental Disorder, list the following as the severity levels for autism spectrum disorders. They are divided into two domains (social communication and social interaction and restrictive, repetitive patterns of behaviors) To fulfill diagnostic criteria for ASD by using the DSM-5 TR, all three symptoms of social affective difference need to be present in addition to 2 of 4 symptoms related to restrictive and repetitive behaviors.

| Severity Level | Social Communication | Restricted, repetitive behaviors |
|---|---|---|
| Level 3<br>"Requiring very substantial support" | Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and when he/she does, makes unusual approaches to meet needs only and responds to only very direct social approaches. | Inflexibility of behavior, extreme difficulty coping with change or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changes focus or action. |
| Level 2<br>"Requiring substantial support" | Marked deficits in verbal and nonverbal communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interest, and who has markedly odd nonverbal communication. | Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer in a variety of context. Distress and/or difficulty changing focus or action. |
| Level 1<br>"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 communication but who's to and from conversation with others fails, | Inflexibility of behavior cases significant interference with functioning in one or more context. Difficulty switching between activities. Problems of organization and planning hamper independence. |

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| | and who attempts to make friends are odd and typically unsuccessful. | |

**Coding Implications**

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2023, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

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

| Reviews, Revisions, and Approvals | Revision Date | Approval Date |
|---|---|---|
| New Policy adapted off the South Carolina Department of Health and Human Services. Autism Spectrum Disorder (ASD) Services Provider Manual. | 03/24 | 05/24 |

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**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers,

members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

**Note: For Medicaid members/enrollees**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members/enrollees,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.