Blue Cross Blue Shield of Michigan GM
Applied Behavior Analysis Medical Necessity Criteria
for Autism Spectrum Disorder

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PURPOSE:
To provide parameters for managing service requests for Applied Behavior Analysis to treat members with Autism Spectrum Disorder so that medical necessity decisions are applied in a consistent and relevant fashion.

Overview

New Directions Behavioral Health® manages Applied Behavior Analysis (ABA) benefits for Blue Cross Blue Shield of Michigan. This medical necessity criteria are used to review and make benefit decisions for ABA service requests for members with the diagnosis of Autism Spectrum Disorder (ASD).

Treatments other than ABA do not fall under the scope of this policy; these services include but are not limited to treatments that are considered to be investigational/experimental, such as Cognitive Training; Auditory Integration Therapy; Facilitated Communication; Higashi Schools/Daily Life; Individual Support Program; LEAP; SPELL; Waldon; Hanen; Early Bird; Bright Start; Social Stories; Gentle Teaching; Response Teaching Curriculum; Holding Therapy; Movement Therapy; Music Therapy; Pet Therapy; Psychoanalysis; Son-Rise Program; Scotopic Sensitivity Training; Sensory Integration Training; Neurotherapy (EEG biofeedback).

ASD is a medical, neurobiological, developmental disorder, characterized by Core Deficit areas: persistent deficits in social communication and social interaction across multiple contexts AND, restricted, repetitive patterns of behavior, interests, and activities. *Diagnostic and Statistical Manual, Fifth Edition (DSM-5)* requires all of these symptoms to be present in early development, and further specifies clinically significant impairment in social, occupational or other important areas of current function.

ABA is currently the behavioral treatment approach most commonly used with children with ASD. The defining characteristics of ABA are applied, behavioral, analytic, technological, conceptually systematic, effective and capable of appropriately generalized outcomes.

ABA involves a structured environment, predictable routines, individualized treatment, transition and aftercare planning, and significant family involvement. ABA attempts to increase skills related to behavioral deficits and reduce behavioral excesses including eliminating barriers to learning. Behavioral deficits may occur in the areas of communication, social and adaptive skills, but are possible in other areas as well. Examples of deficits may include: a lack of expressive language, inability to request items or actions, limited eye contact with others, and inability to engage in age-appropriate self-help skills such as tooth brushing or dressing. Examples of behavioral excesses may include, but are not limited to: physical aggression, property destruction, elopement, self-stimulatory behavior, self-injurious behavior, and vocal stereotypy.

Treatment of Autism requires a comprehensive assessment be completed to identify competing or co-morbid medical/behavioral diagnosis and/or competing developmental delays that potentially impact treatment planning. The comprehensive evaluation, in addition to making a diagnostic determination, should evaluate the member's current cognitive and adaptive functioning as well as determine the severity of the member's autism condition.

Cognitive and adaptive behavior assessments define baseline measurements as a part of the measure for progress in ABA treatment. In the peer reviewed literature, improvements in cognitive and adaptive testing are used to demonstrate treatment outcomes and efficacy. The cognitive assessment additionally sets a baseline for cognitive functioning which is an essential component in treatment. Adaptive behavior scales are highly useful for focused treatment. As aberrant behavior decreases, these should be replaced by more appropriate skills, resulting in score increase. Similarly, social skills training, when successful should increase the social and communication score in a positive direction.

A recently developed metric for Autism Diagnostic Observation Scale (ADOS) scoring allows a calibrated severity score to be assigned to each patient. This makes it possible to compare score's longitudinally. The depth of concordance with the current diagnostic criteria for ASD also provides scoring cutoffs to make a formal diagnosis of ASD.

During initial assessment, target symptoms are identified. A treatment plan is developed that identifies the core deficits and aberrant behaviors, and includes designated interventions intended to address these deficits and behaviors and achieve individualized goals. Treatment plans are usually reviewed for medical necessity (defined below) twice annually (frequency dependent upon the controlling state mandate) to allow re-assessment and to document treatment progress

A Functional Behavioral Assessment (FBA) may also be a part of any assessment. A FBA consists of

a. Description of the problematic behavior (topography, onset/offset, cycle, intensity, severity)
b. History of the problematic behavior (long-term and recent)
c. Antecedent analysis (setting, people, time of day, events)
d. Consequence analysis
e. Impression and analysis of the function of the problematic behavior

Requests for telehealth/telemedicine ABA services will be reviewed in accordance with current controlling health plan guidelines. Unless superseded by health plan guidelines, New Directions considers telehealth for direct ABA services (e.g., 97152, 97153, 97154, 0373t) to be experimental/investigational. Telehealth/telemedicine for parent education (e.g., 97156 and 97157), direct supervision activities (e.g., 97155, 97158), and some assessment activities (97151) can be covered if allowed as an eligible telehealth/telemedicine service under the member benefit plan. When possible, it is recommended that telehealth/telemedicine service delivery be combined with face-to-face service delivery of direct supervision activities.

Medical Necessity
Medical necessity is defined in the controlled specific health plan and/or group documents.

COVERAGE GUIDELINES: INITIAL SERVICE REQUEST

New Directions authorizes ABA services for ASD when the following comprehensive diagnostic evaluation criteria are met:

COMPREHENSIVE DIAGNOSTIC EVALUATION

1. The member has a diagnosis of Autism Spectrum Disorder (ASD) from a clinician who is licensed and qualified to make such a diagnosis. Such clinicians are usually a: neurologist, developmental pediatrician, pediatrician, psychiatrist, licensed clinical psychologist, or medical doctor experienced in the diagnosis of ASD. State mandates may define eligible qualified clinicians.
    a. Documentation of the diagnosis must be accompanied by a clinical note of sufficient depth that allows concordance with DSM-5criteria for core symptoms of ASD. Please note: Autism screening measures indicate the level of risk for disability as opposed to the provision of a diagnosis. Screening measures are not appropriate standalone support for an autism diagnosis and should be followed up by an in-depth assessment, which should include an ASD-specific standardized assessment.
    b. The comprehensive evaluation must rule out behavior/ medical diagnoses that potentially have similar symptom presentations. This includes neurological disorders, hearing disorders, behavior disorders, and other developmental delays.
2. Member is within the age range specified in the applicable health plan's member service plan description or in the applicable state mandate for treatment.

ABA SERVICE REQUEST FOR ASSESSMENT

MUST MEET ALL OF THE FOLLOWING:

1. A diagnosis of ASD is provided and diagnostic criteria as set forth in the current DSM are documented in the medical record
2. Hours requested are not more than what is required to complete the treatment assessment.
3. For initial ABA treatment assessment, the following assessments must have been completed prior to or scheduled within 90 days of the assessment. Baseline data must have been completed no longer than 5 years prior to the initial treatment assessment or as indicated below. Please see definitions sections for more information.
4. Developmental and cognitive evaluation
5. Autism-specific assessment that identifies the severity of the condition
6. Additional clinical rationale is required for authorization of more than 8 hours of assessment codes 97151 and 97152 for the initial assessment.

Note: *Standardized psychological testing services are billed with specific psychological testing AMA-CPT code by eligible providers. Typically, a clinical psychologist is qualified to provide testing services.*

INITIAL ABA AUTHORIZATION REQUEST

MUST MEET ALL OF THE FOLLOWING:

1. Diagnostic Criteria as set forth in the current DSM-5 are met.
2. Documentation of psychological assessment, including autism-specific testing and cognitive evaluation to define baseline functioning. Any assessment should be accompanied by a formal report detailing the scores achieved and the results of the assessment.
3. ABA services do not duplicate services that directly support academic achievement goals that are or could be included in the member's educational setting or the academic goals encompassed in the member's Individualized Education Plan (IEP)/Individualized Service Plan (ISP). This includes shadow, para-professional, interpersonal or companion services in any setting that are implemented to directly support academic achievement goals.
4. The ABA services recommended do not duplicate services provided or available to the member by other medical or behavioral health professionals. Examples include but are not limited to behavioral health treatment such as individual, group, and family therapies; or occupational, physical, and speech therapies.
5. Approved treatment goals and clinical documentation must be focused on active ASD core symptoms, substantial deficits that inhibit daily functioning, and clinically significant aberrant behaviors that require the expertise of a Licensed Behavior Analyst This includes a plan for stimulus and response generalization in novel contexts.
6. When there is a history of ABA treatment, the provider reviews the previous ABA treatment record to determine that there is a reasonable expectation that a member has the capacity to learn and generalize skills to assist in his or her independence and functional improvements.
7. For comprehensive treatment, the requested ABA services are designed to reduce the gap between the member's chronological and developmental ages such that the member is able to develop or restore function to the maximum extent practical.
8. For focused treatment, the requested ABA services are designed to reduce the burden of selected targeted symptoms on the member, family and other significant people in the environment and to target increases in appropriate alternative behaviors.
9. Treatment intensity does not exceed the member's functional ability to participate and/or is not for the convenience of the patient, caregiver, treating provider or other professional.
10. Hours per week requested are not more than what is required to achieve the goals listed in the treatment plan and must reflect the member's, caregiver's, and provider's availability to participate in treatment.
11. Treatment occurs in the setting(s) where target behaviors are occurring and/or where treatment is most likely to have an impact on target behaviors unless the setting is excluded by the member's benefit plan.
12. Direct line therapy services are provided by a Registered Behavior Technician (RBT), or Licensed Assistant Behavior Analyst, supervised by a Master level or Doctoral level Board Certified Behavior Analyst, or provided in a manner consistent with the controlling state mandate.

13. The treatment plan must include a plan to support the member's ability to generalize skills across stimuli, contexts and individuals, via caregiver training or an appropriate alternative. Provider should be able to demonstrate how instructional control will be transferred to caregivers to include either:
    a. A plan for caregiver training that includes assessment of the caregivers' skills, measurable goals for skill acquisition and monitoring of the caregivers' use of skills. Generalization of skills should be assessed during parent/caregiver training to ensure the member can demonstrate skill with caregivers in the natural environment during non-therapeutic times. Documentation may be requested to assess the caregivers' ability to implement treatment plan procedures and recommendations to evaluate the following areas.
        i. Member's ability to demonstrate the use of replacement skills and/or reductions in aberrant behavior in natural settings.
        ii. Family/caregivers' ability to successfully prompt and teach skills and effectively use behavior reduction strategies.
        iii. The Behavioral Analyst can assess treatment effectiveness during non-therapeutic times.
        iv. An alternative plan if caregiver participation does not result in generalization of skills.
    b. In the absence of successful caregiver involvement in treatment, provider should identify an appropriate alternate plan to promote the member's ability to generalize skills outside of therapy sessions, including post-discharge.
14. A complete medical record is submitted by the Licensed Behavior Analyst (LBA) to include:
    a. All assessments performed by the Licensed Behavior Analyst using direct observation.
    b. Preferred skills assessments must be developmentally and age appropriate and include non-standardized curriculum assessments such as the ABLLS, VB-MAPP, and other developmental measurements employed during initial assessments. Only those portions of assessments that address core deficits of autism are considered to be medically necessary; this excludes assessments or portions of assessments that cover academic, speech, vocational skills, etc. Standardized adaptive behavior assessment tools are not accepted in lieu of curricular assessment tools. Individualized treatment plan with clinically significant and measurable goals that clearly address the member's active core deficits of ASD.
    c. Goals should include date of treatment introduction, measured baseline of targeted goal, objective present level of behavior, mastery criteria, estimated date of mastery, and a specific plan for generalization of skills.
    d. Functional Behavior Assessment to address targeted problematic behaviors with operational definition and provide data to measure progress, as clinically indicated.
    e. Documentation of treatment participants, procedures and setting.
    f. Plan for coordination of care with member's other qualified health care professionals to communicate pertinent medical and/or behavioral health information.
    g. When applicable, plan for coordination with New Directions Behavioral Health Case Management activities.

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SERVICE INTENSITY CLASSIFICATION:

Comprehensive treatments range from 25 to 40 total hours of direct services weekly. New Directions will review each request on an individual basis for fidelity to medical necessity and approve total hours based on the member's severity, intensity, frequency of symptoms, and response to previous and current ABA treatment. Comprehensive treatment includes direct 1:1 ABA, caregiver training, supervision and treatment planning.

Comprehensive ABA treatment targets members whose treatment plans address deficits in all core symptoms of Autism. Appropriate examples of comprehensive treatment include Early Intensive Behavioral Intervention (EIBI) and treatment programs for older children with aberrant behaviors across multiple settings. This treatment level, which requires very substantial support, should initially occur in a structured setting with 1:1 staffing and should advance to the least restrictive environment appropriate for the member This treatment is primarily directed to children ages 3 to 8 years old because Comprehensive ABA treatment has been shown to be most effective with this population in current medical literature. Caregiver training is an essential component of Comprehensive ABA treatment.

Focused treatments range from 10 to 25 total hours per week. New Directions will review each request on an individual basis for fidelity to medical necessity and approve total hours based on the member's severity, intensity, frequency of symptoms, and response to previous and current ABA treatment. This treatment may include individual services, group services and caregiver training.

Focused treatment typically targets a limited number of behavior goals requiring support of ABA treatment. Behavioral targets include marked deficits in social communication skills and restricted, repetitive behavior such as difficulties coping with change. In cases of specific aberrant and/or restricted, repetitive behaviors, attention to prioritization of skills is necessary to prevent and offset exacerbation of these behaviors, and to teach new skill sets. Identified aberrant behaviors should be addressed with specific procedures outlined in a Behavior Intervention Plan. Emphasis is placed on group work and parent training to assist the member in developing and enhancing his/her participation in family and community life, and developing appropriate adaptive, social or functional skills in the least restrictive environment.

Requested treatment hours outside of the range for Comprehensive or Focused treatment will require a specific clinical rationale.

Hours to be Authorized

Total authorized hours will be determined based on all of the following:

- The current medical policy and medical necessity
- Provider treatment plan, that identifies suitable behaviors for treatment and improves the functional ability across multiple contexts
- Severity of symptoms, including aberrant behaviors
- Continued measurable treatment gains and response to previous and current ABA treatment.

- Hours per week requested are not more than what is required to achieve the goals listed in the treatment plan and must reflect the member's, caregiver's, and provider's availability to participate in treatment.

Caseload Size

The Council on Autism Service Provider's ("CASP") Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers, 2nd Edition, states that Licensed Behavior Analysts should carry a caseload that allows them to provide appropriate case supervision to facilitate effective treatment delivery and ensure consumer protection.

Caseload size for the Licensed Behavior Analyst is typically determined by the following factors:

- Complexity and needs of the clients in the caseload
- Total treatment hours delivered to the clients in the caseload
- Total case supervision and clinical direction required by caseload
- Expertise and skills of the Licensed Behavior Analyst;
- Location and modality of supervision and treatment (for example, center vs. home, individual vs. group,)
- Availability of support staff for the Licensed Behavior Analyst (for example, a Licensed Assistant Behavior Analyst).

The recommended caseload range for one (1) Licensed Behavior Analyst is as follows:

Supervising Focused Treatment

- Without support of a Licensed Assistant Behavior Analyst is 10 - 15*
- With support of one (1) Licensed Assistant Behavior Analyst is 16 - 24*

Additional Licensed Assistant Behavior Analysts permit modest increases in caseloads.

* Focused treatment for severe problem behavior is complex and requires considerably greater levels of case supervision, which will necessitate smaller caseloads.

Supervising Comprehensive Treatment

- Without support of a Licensed Assistant Behavior Analyst is 6 - 12
- With support of one (1) Licensed Assistant Behavior Analyst is 12 - 16

Additional Licensed Assistant Behavior Analysts permit modest increases in caseloads.

CONTINUED ABA AUTHORIZATION REQUEST

Member must demonstrate clinically significant improvement or progress achieving goals for successive authorization periods or benefit coverage of ABA services may be reduced or denied.

MUST MEET ALL OF THE FOLLOWING:

1. Criteria 1-13 in the INITIAL ABA AUTHORIZATION REQUEST section are met.
2. Member shows clinically significant progress in generalizing skills across stimuli, contexts and individuals, via caregiver training or an appropriate alternative. Provider must be able to demonstrate how operational control is being transferred to caregivers.
3. A complete medical record is submitted by the Licensed Behavior Analyst to include:
    a. All re-assessments performed by the Licensed Behavior Analyst, using direct observation.
    b. Preferred skills assessments that are developmentally and age appropriate and include non-standardized curriculum assessments such as the ABLLS, VB-MAPP, or other developmental measurements employed during initial assessments. Only those portions of assessments that address core deficits of autism are considered to be medically necessary; this excludes assessments or portions of assessments that cover academic, speech, vocational skills, etc.
        i. Non-standardized curriculum assessment should be completed every 6 months
        ii. Standardized adaptive behavior assessment tools are not accepted in lieu of curricular assessment tools.
    c. Individualized treatment plan with clinically significant and measurable goals that clearly address the member's active core deficits of ASD. Goals should include date of treatment introduction, measured baseline/present level of performance of the targeted goal, objective present level of behavior, mastery criteria, estimated date of mastery, and a specific plan for generalization of skills.
    d. Functional Behavior Assessment to address targeted problematic behaviors with operational definition and provide data to measure progress, as clinically indicated.
    e. Documentation of treatment participants, procedures and setting.
4. Current ABA treatment documentation demonstrates clinically significant progress to develop or restore the member's adaptive function.
    a. There is a reasonable expectation of mastery of proposed goals within the requested six-month treatment period.
    b. There is a reasonable expectation that achievement of goals will result in functional improvement and assist in the member's independence to reduce the need for custodial, respite, interpersonal or paraprofessional care or other support services.
    c. The member demonstrates the capacity to develop and generalize clinically significant skills to assist in his or her independence in order to reduce the need for custodial, respite, interpersonal or paraprofessional care or other support services.
    d. Members in treatment demonstrate clinically significant improvement as evidenced by significant increase (e.g., one standard deviation) on standardized adaptive or cognitive testing in the previous year, as opposed to declining or plateaued scores OR as evidenced by mastery of a minimum of 50 percent of goals in the previously submitted treatment plan and the achievement of treatment plan goals will assist in the member's independence and functional improvement. Members who do not master 50 percent of stated goals and/or do not demonstrate measurable and clinically significant progress toward developing or restoring the maximum function of the member, the treatment plan should clearly address the barriers to treatment success. New Directions may request further standardized testing be obtained to clarify current level of functional abilities.

e. If six-month goals are continued into the next treatment plan, these goals should be connected to long term goals that are clinically significant and with a reasonable expectation of mastery. When the mastery criteria have been modified to meet an incremental short-term objective, the overall goal is considered to be "continued".
f. Standardized adaptive testing should be completed annually and results should be submitted with the request for continued treatment.

5. Transition and aftercare planning information should be included in each review and should:
    a. Begin during the early phases of treatment and will change over time based upon response to treatment and presented needs.
    b. Focus on the skills and supports required for the member for transitioning toward their natural environment, as appropriate to their realistic developmental abilities.
    c. Identify appropriate services and supports for the period following ABA treatment.
    d. Include a planning process and documentation with active involvement and collaboration with a multidisciplinary team to include caregivers.
    e. Long term outcomes must be developed specifically for the individual with ASD, be functional in nature, and focus on skills needed in current and future environments.
    f. Realistic expectations should be set with current treatment plan goals connecting to long term outcomes.
6. Additional clinical rationale is required for more than 6 hours of assessment codes 97151 and 97152 for the six-month reassessment.

State mandates and the controlling health plan may have benefit limitation and exclusions not listed in this medical policy.

DEFINITIONS:

- **Behavior Intervention Plan**: A written document that describes a pattern of aberrant behavior, the environmental conditions that contribute to that pattern of behavior, the supports and interventions that will reduce the behavior and the skills that will be taught as an alternative to the behavior.
- **Caregiver Training**: Caregiver participation is a crucial part of ABA treatment and should begin at the onset of services. Provider's clinical recommendations for amount and type of caregiver training sessions should be mutually agreed upon by caregivers and provider.
    a. Caregiver training is defined as the education and development of caregiver-mediated ABA strategies, protocols, or techniques directed at facilitating, improving, or generalizing social interaction, activities of daily living, skill acquisition and behavior management, to include observational measures for assurance of treatment integrity. Caregiver training is necessary to address member's appropriate generalization of skills, including activities of daily living,

and to potentially decrease familial stressors by increasing member's independence.

b. Caregiver training goals submitted for each authorization period must be specific to the member's identified needs and should include goal mastery criteria, data collection and behavior management procedures if applicable, and procedures to address ABA principles such as reinforcement, prompting, fading and shaping. Each caregiver goal should include date of introduction, current performance level and a specific plan for generalization. Goals should include measurable criteria for the acquisition of specific caregiving skills.
c. It is recommended that one hour of caregiver training occurs for the first 10 hours of direct line therapy, with an additional 0.5 hours for every additional 10 hours of scheduled direct line therapy unless contraindicated or caregiver declines. Caregiver training hours should increase to a higher ratio of total direct line therapy hours if member goals address activities of daily living, as provider plans for transition to lower level of care within the next 6 months or, as member comes within one year of termination of benefits based on benefit coverage.
d. If parents decline or are unable to participate in caregiver training, a generalization plan should be created to address member's skill generalization across environments and people.
e. Caregiver training does not include training of teachers, other school staff, other health professionals or other counselors or trainers in ABA techniques. However, caregiver training can include teaching caregivers how to train other professionals or people involved in the member's life.

- **Clinically Significant**: Clinical significance is the measurement of practical importance of the treatment effect – whether it creates a meaningful difference and has an impact that is noticeable in daily functioning
- **Core Deficits of Autism**: persistent deficits in social communication and social interaction across multiple contexts AND, restricted, repetitive patterns of behavior, interests and activities
- **Functional Behavior Assessment**: comprises descriptive assessment procedures designed to identify environmental events that occur just before and just after occurrences of potential target behaviors and that may influence those behaviors. That information may be gathered by interviewing the member's caregivers; having caregivers complete checklists, rating scales, or questionnaires; and/ or observing and recording occurrences of target behaviors and environmental events in everyday situations. (AMA CPT, 2021)
- **Generalization**: skills acquired in one setting are applied to many contexts, stimuli, materials, people and/or settings to be practical, useful and functional for the individual. Generalized behavior change involves systematic planning and needs to be a central part of every intervention and every caregiver training strategy. When the member accomplishes generalization, this increases the likelihood of completing tasks independently.
- **Interpersonal Care:** interventions that do not diagnose or treat a disease, and that provide either improved communication between individuals, or a social interaction replacement

- **Long-Term Objective:** An objective and measurable goal that details the overall terminal mastery criteria of a skill being taught. Specifically, this terminal mastery criteria will indicate that a member can demonstrate the desired skill across people, places and time, which suggests the skill no longer requires further teaching.
- **Mastery Criteria**: objectively and quantitatively stated percentage, frequency or intensity and duration in which a member must display skill/behavior to be considered an acquired skill/behavior, including generalization and maintenance
- **Neurological Evaluation**: This needs to be completed and documented on every member by a licensed physician as part of the diagnostic evaluation. Any significant abnormalities on the minimal elements of an exam should trigger a referral to a neurologist to perform comprehensive testing to assess neurological abnormalities. Minimal elements include:
  Evaluation of Cranial nerves I-XII
  Evaluation of all four extremities, to include motor, sensory and reflex testing
  Evaluation of coordination
  Evaluation of facial and/or somatic dysmorphism
  Evaluation of seizures or seizure-like activity
- **Non-standardized instruments:** include, but not limited to, curriculum-referenced assessment, stimulus preference- assessment procedures, and other procedures for assessing behaviors and associated environmental events that are specific to the individual patient and behaviors. (AMA CPT, 2021)
- **Operational Control**: Instructional control is a productive working relationship between the instructor and learner. Obtaining instructional control through a variety of behavior analytic strategies increases the likelihood that the learner will consistently comply with a task or demand presented by the instructor.
- **Paraprofessional Care:** services provided by unlicensed persons to help maintain behavior programs designed to allow inclusion of members in structured programs or to support independent living goals except as identified in state mandates or benefit provisions
- **Present Level of Performance**: objective and quantitative measures of the percentage, frequency or intensity and duration of skill/behavior prior to intervention
- **Qualified Healthcare Professional**: an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. These professionals are distinct from “clinical staff”. A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specified professional service but who does not individually report that professional service.
- **Respite Care**: care that provides respite for the individual’s family or persons caring for the individual
- **Short-Term Objective**: An intermediate, objective and measurable goal that details the incremental increases a member must demonstrate in moving toward the identified Long-Term Objective.

- **Standardized Assessments**: include, but not limited to, behavior checklists, rating scales and adaptive skill assessment instruments that comprise a fixed set of items and are administered and scored in a uniform way with all patients. (AMA CPT, 2021 The listed assessments are not meant to be exhaustive but serve as a general guideline to quantify baseline intelligence and adaptive behaviors and when repeated, measure treatment outcomes. The autism specific assessments assist not only in the confirmation of diagnosis but more importantly, in the severity and intensity of the baseline core ASD behaviors.

DIAGNOSTIC INSTRUMENTS AND SCREENING ASSESSMENTS:

Screening Measures: These are brief assessments designed to identify children who need a comprehensive evaluation secondary to risks associated with delay, disorder or disease that will interfere with normal development. Screening measures differ from diagnostic measures in that they typically require less time and training to administer and have high rates of false positives. Results of screening measures indicate the level of risk for disability as opposed to the provision of a diagnosis. Screening measures are not appropriate standalone support for an autism diagnosis and should be followed up by in-depth assessments. Additional acceptable documentation includes autism-specific standardized assessments, or a detailed clinical note based on a comprehensive review of DSM-5 signs and symptoms. Examples of screening measures include:

- Autism Spectrum Rating Scale (ASRS), short form
- Childhood Autism Rating Scale, second edition. (CARS-2)
- Childhood Autism Spectrum Test. (CAST)
- Social Communications Questionnaire (SCQ)
- Autism Behavior Checklist (ABC)
- Gillian Autism Rating Scale (GARS)
- Checklist for Autism in Toddlers (CHAT)
- MCHAT R F with follow up questions (score 3-7)
- MCHAT R without follow up questions (score 8-20)

Diagnostic assessments: These offer significant detail concerning specific deficits and/or survey a broader swath of core behaviors in autism. Reliability and validity of the instrument are defined in depth. Reliability gauges the extent to which the instrument is free from measurement errors across time, across raters and within the test. Validity is the degree to which other evidence supports inferences drawn from the scores yielded by the instrument. This is often grouped into content, construct and criteria related evidence. These assessments also provide a measure for severity of illness.

Standardized Autism Diagnostic Assessments

- Autism Diagnostic Observation Schedule, second edition (ADOS-2)
- Autism Diagnostic Interview, revised (ADI-R)
- Social Responsiveness Scale, second edition (SRS-2)
- DSM-5 Checklist

Standardized Adaptive Assessment Instruments

Adaptive assessments are a type of psychological testing, which is vetted, standardized and norm referenced. These assessments provide a pathway to allow comparison of an individual member's score to a norm-referenced mean.

- Vineland Adaptive Behavior Scale (VABS)
- Adaptive Behavior Assessment Scale (ABAS)

- Behavior Assessment System for Children (BASC)
- Pervasive Developmental Disorder Behavior Inventory (PDDBI)

Standardized Cognitive Assessments

- Leiter International Performance Scale-R
- Mullen Scales of Early Learning
- Bayley Scales of Infant Development
- Kaufmann Assessment Battery for Children, second edition (K-ABC-II)
- Wechsler Preschool and Primary Scale of Intelligence, third edition (WPPSI-III)
- Wechsler Intelligence Scale for Children, fourth edition (WISC-IV)
- Test of Non-Verbal Intelligence, fourth edition (TONI-4)

Non-Standardized Curricular Assessments

These tools are developed to provide a curriculum-based individual assessment. They are criterion-refenced, as opposed to psychological testing, which is vetted, standardized and norm referenced. The latter provide a pathway to allow comparison of an individual member's score to a norm-referenced mean. Examples include:

- Assessment of Basic Language and Learning Skills (ABLLS)
- Verbal Behavior Milestones Assessment and Placement Program (VBMAPP)
- PEAK
- Essentials For Living (EFL)
- Assessment of Functional Living Skills (AFLS)