NEW DIRECTIONS BEHAVIORAL HEALTH, L.L.C.

Medical Policy	Applied Behavior Analysis for the Treatment of Down Syndrome

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PURPOSE:

To provide parameters for managing service requests for Applied Behavior Analysis to treat members with Down syndrome 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 various health plans. This medical policy is used to review and make benefit decisions for ABA service requests for members with the diagnosis of Down syndrome (DS). This benefit for Down's syndrome is mandated in the State of Florida, beginning July 1, 2016. Note that comorbid diagnoses of Down syndrome and Autism Spectrum Disorder (ASD) will be managed by the ABA for ASD Medical Policy.

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).

Down syndrome is a condition in which a person has an extra chromosomal material. Typically, an individual is born with 46 chromosomes. People with Down syndrome have an extra copy of one of these chromosomes 21. This disorder is also called Trisomy 21. This extra genetic material changes how the body and brain develop, which can cause both mental and physical challenges. Even though people with Down syndrome might act and look similar, there are significant individual differences. The IQ is generally in the mildly-to-moderately low range and language development is delayed.

Some common physical features of Down syndrome include:

- A flattened face, especially the bridge of the nose
- Almond-shaped eyes that slant up
- A short neck
- Small ears

- A tongue that tends to stick out of the mouth
- Tiny white spots on the iris (colored part) of the eye
- Small hands and feet
- A single line across the palm of the hand (palmar crease)
- Small pinky fingers that sometimes curve toward the thumb
- Poor muscle tone or loose joints
- Shorter in height as children and adults

There are three types of Down syndrome. Despite these differences in genetic material, the physical features and behaviors are similar.

Trisomy 21: About 95% of people with Down syndrome have Trisomy 21. With this type of Down syndrome, each cell in the body has 3 separate copies of chromosome 21 instead of the usual 2 copies.

Translocation Down syndrome: This type accounts for a small percentage of people with Down syndrome (about 3%). This occurs when an extra part or a whole extra chromosome 21 is present, but it is attached to a different chromosome rather than being a separate chromosome 21.

Mosaic Down syndrome: This type affects about 2% of the people with Down syndrome. Mosaic means mixture or combination. For children with mosaic Down syndrome, some of their cells have 3 copies of chromosome 21, but other cells have the typical two copies of chromosome 21. Children with mosaic Down syndrome may have the same features as other children with Down syndrome. However, they may have fewer features of the condition due to the presence of some (or many) cells with a typical number of chromosomes

ABA therapy is the behavioral treatment approach. Techniques based on ABA include: Discrete Trial Training, Incidental Teaching, Pivotal Response Training, and Verbal Behavioral Intervention. 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. 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.
At an 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

MEDICAL NECESSITY:
Medical necessity is defined in the controlling specific health plan and/or group documents.

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
- **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.

Please refer to Guidelines for Treatment Record Documentation section of New Directions' Provider Manual for standards on client file documentation.

New Directions will review requests for ABA treatment benefit coverage based upon clinical information submitted by the provider.

COVERAGE GUIDELINES: INITIAL SERVICE REQUEST

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

COMPREHENSIVE DIAGNOSTIC EVALUATION

1. The member has a diagnosis of Down Syndrome (without a comorbid diagnosis of ASD) from a clinician who is licensed and qualified to make such a diagnosis and confirmed by genetic testing
2. Member is within the age range specified in the applicable health plan's member service plan description or in the Florida state mandate for treatment.

ABA SERVICE REQUEST FORASSESSMENT

MUST MEET ALL OF THE FOLLOWING:

1. Diagnostic Criteria as set forth in the current DSM are met.

2. Hours requested are not more than what is required to complete the treatment assessment.
3. For initial ABA treatment assessment, the following baseline data 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 section for more information.
    a. Developmental and cognitive evaluation
    b. Adaptive behavior assessment completed within 6 months of start date of treatment
    c. Neurological evaluation as part of a comprehensive physical examinatoin
    d. Information applicable to state mandate
4. Additional clinical rationale is required for authorization of more than 8 hours of assessment codes 97151 and 97152 for the initial assessment.

Note: Only CPT odes identified in this document will be approved for, the ABA assessment process. Standardized psychological testing services are billed with specific psychological testing AMA-CPT code by eligible providers. Typically, only 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 adaptive behavior 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).
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 symptoms, substantial deficits that inhibit daily functioning, and clinically significant aberrant behaviors that require the expertise of a 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 Board Certified 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 Behavior Analyst to include:
    a. All assessments performed by the Behavior Analyst, utilizing direct observation.
    b. Preferred skills assessments must be developmentally and age appropriate and include non-standardized curriculum assessments such as the ABLLS, VB-

MAPP, or other developmental measurements employed. Only those portions of assessments that address clinically significant behavior deficits that are related to the symptoms of Down syndrome are considered 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 active symptoms and signs of the member's DS.

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 providers to communicate pertinent medical and/or behavioral health information.

g. When applicable, plan for coordination with New Directions Behavioral Health Case Management activities.

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 Behavior Analyst to include:

- **a.** All re-assessments performed by the 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 clinically significant behavior deficits that are related to the symptoms of Down syndrome 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 measurable goals that clearly address the active symptoms and signs of the member's DS. 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

f. Coordination of care with member's other qualified health care professionals to communicate pertinent medical and/or behavioral health information.

g. When applicable, coordination with New Directions Behavioral Health Case Management activities.

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

5. Transition and aftercare planning 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 Down syndrome, 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 6-month reassessment.

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 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 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 Behavior Analyst
- Location and modality of supervision and treatment (for example, center vs. home, individual vs. group,)
- Availability of support staff for the Behavior Analyst (for example, an Assistant Behavior Analyst_

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

Supervising Focused Treatment

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

Additional 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 an Assistant Behavior Analyst is 6 - 12
- With support of one (1) Assistant Behavior Analyst is 12 - 16

Additional Assistant Behavior Analysts permit modest increases in caseloads.

DIAGNOSTIC INSTRUMENTS AND SCREENING ASSESSMENTS:

Standardized Adaptive Assessment Instruments

- 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)

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

DIAGNOSTIC AND BILLING CODES

ICD-10 Codes

Q90	**Down Syndrome**
Q90.0	**Down Syndrome: trisomy 21, meiotic nondisjunction**
Q90.1	**Down syndrome: trisomy 21, mosaicism (mitotic nondisjunction)**
Q90.2	**Down syndrome: trisomy 21, translocation**
Q90.9	**Down syndrome, unspecified**

ABA Services that require two or more staff members will only be billed as one service provided by the rendering provider.

CPT CODES

All ABA codes are billed in 15 minute units. "If the Behavior Analyst or other qualified health care professional personally performs the line technician activities, his or her time engaged in these activities should be included as part of the line technician's time to meet the components of the code." AMA CPT, 2021, page 786

97151 BEHAVIOR IDENTIFICATION ASSESSMENT

- Conducted by Behavior Analyst or qualified health care professional, includes face-to-face and non-face-to-face components, including:
    - Face to face member assessment component
    - Review of history of current and past behavioral functioning
    - Review of previous assessments and health records
    - Interview parent/caregiver to further identify and define deficient adaptive or maladaptive behaviors
    - Administration of non-standardized test such as VB-MAPP, ABLLS, EFL
    - Interpretation of results
    - Discussions of findings and recommendations with primary caregiver(s)
    - Preparation of report
    - Development of care plan and which may include behavior identification supporting assessment (97152) or behavior identification assessment with four required components (0362T)
- May be reported only once within a six-month interval.

97152 BEHAVIOR IDENTIFICATION SUPPORTING ASSESSMENT

- Face to Face with member
- May include collection of data for functional behavior assessment, functional analysis, or other structured procedures
- Utilized to evaluate deficient adaptive behavior(s) maladaptive behavior(s), or other impaired functioning in the following:
    - Communication: receptive and expressive language, echolalia, lack of pragmatic language, visual understanding, requests and labeling

- Social behavior: lack of empathy, lack of social reciprocity, little or no functional play skills cooperation, motivation, imitation, play and leisure, and social interactions
- Ritualistic and repetitive behaviors, self-injurious behaviors, and other aberrant behaviors (property destruction, aggression, elopement, etc.) which do not require the intensity of the 0362T code to assess.

- Line Therapist may complete under direction of Behavior Analyst, qualified professional off-site.
- The time that the member is face to face with the line therapist(s) correlates with the physician's or other qualified health care professional's work, which includes technician direction; analysis of results of testing and data collection; preparation of report and plan of care; and discussion of findings and recommendations with the primary guardian(s)/ caregiver(s)
- Additional clinical rationale is required for more than a total 8 hours of the initial assessment and for more than a total of 6 hours for six-month reassessments for 97151 and 97152, in any combination of usage

97153 ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL

- May be administered by a line therapist
- Face to face with one member
- Behavior Analyst or qualified health care provider directs service by:
  - Designing treatment plan goals and objectives
  - Analyzing data
  - Determining whether use of treatment goals and objectives is producing adequate progress

97154 GROUP ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL

- May be administered by a line therapist
- Face to face with two or more members
- Behavior Analyst or qualified health care provider directs service by:
  - Designing treatment plan- goals and objectives
  - Analyzing data
  - Observation of treatment implementation for potential program revision,
  - Determining whether use of treatment goals and objectives is producing adequate progress
- Maximum members per group - 8

97155 ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL MODIFICATION

- Administered by a Behavior Analyst or qualified health care professional
- Face to face with a single member or member and line technician
- Resolves one or more problems with the protocol and may simultaneously direct a line technician in administering the modified protocol while member is present
- Direction to technician without the member present is not reported separately
- Billing for the time of this activity is allowed only for a Behavior Analyst or qualified health professional time even if other professional providers are present.

Clinical rationale must be provided for requests that exceed 2 hours of adaptive behavior treatment protocol modification per 10 hours of adaptive behavior treatment by protocol.

Adaptive treatment protocol modification may include the following: design, analysis and edits to antecedent or consequence strategies, individualized behavior plan based on functions maintaining aberrant behavior, inclusion of additional acquisition/replacement skills to current treatment plan or analysis and editing of prompt fading, chaining, differential reinforcement or generalization procedures, which require the expertise of a Behavior Analyst.

The following examples would not be considered protocol modification for purposes of billing this code and are part of the 97153 and 97155 codes: conducting preference assessments and altering reinforcement and/or implementation of skill acquisition and behavior reduction programs.

Only face to face time may be billed. Pre/post time including direction of line therapist without the member present and analysis of data collection are included in the valuation of the code reimbursement. The technician's time (97153) may not be billed concurrently and is a component included in the valuation of this code.

97156 FAMILY ADAPTIVE BEHAVIOR TREATMENT GUIDANCE

- Administered by a Behavior Analyst or qualified health care professional
- Face to face with parents, guardian, and caregiver with or without members present
- Utilized to implement treatment protocols designed to address deficient adaptive or maladaptive behaviors

97157 MULTIPLE FAMILY GROUP ADAPTIVE BEHAVIOR TREATMENT GUIDANCE

- Administered by a Behavior Analyst or qualified health care professional
- Face to face with parents, guardians and/or caregivers of multiple members without members present
- Utilized to implement treatment protocols designed to address deficient adaptive or maladaptive behaviors
- Maximum members per group - 8

This code is typically used during the initial treatment phase to educate and orient families in ABA behavioral nomenclature and techniques

97158 GROUP ADAPTIVE BEHAVIOR TREATMENT WITH PROTOCOL MODIFICATION

- Administered by a Behavior Analyst or qualified health care professional
- Face to face with two or more members
- Member must have direct participation in treatment protocol/interactions in order to meet their own individual treatment goals
- Protocol adjustments are made in real time dynamically during the session
- Maximum members per group – 8

This code entails differentiating prompting methods, instruction, antecedent/consequence strategies, varying goals/skills and reinforcement schedules in real time with multiple members simultaneously

0362T BEHAVIOR IDENTIFICATION SUPPORTING ASSESSMENT WITH FOUR REQUIRED COMPONENTS

- On-site direction by a Behavior Analyst, qualified health care professional
- With the assistance of two or more line therapists/ assistants to assist in treatment protocol with supervision of a Behavior Analyst, qualified health care professional
- For member who exhibits destructive behavior (e.g., elopement, pica, or self-injury requiring medical attention; aggression with injury to other(s); or breaking furniture/walls/ windows)
- Requires safe, structured customized environment with possible use of protective gear and padded room
- Requires clinical rationale for need based on frequency, severity, and intensity of the destructive behaviors

Behavior Analyst/qualified health care professional shapes environmental or social contexts to examine triggers, events, cues, responses and consequences linked to maladaptive destructive behaviors.

0373T ADAPTIVE BEHAVIOR TREATMENT WITH PROTOCOL MODIFICATION WITH FOUR REQUIRED COMPONENTS

- On-site direction by a Behavior Analyst. A, qualified health care professional
- With the assistance of two or more line therapists/ assistants to assist in treatment protocol with supervision of a Behavior Analyst qualified health care professional
- For member who exhibits destructive behavior (e.g., elopement, pica, or self-injury requiring medical attention; aggression with injury to other(s); or breaking furniture/walls/ windows)
- Requires safe, structured customized environment with possible use of protective gear and padded room
- Requires clinical rationale for need based on frequency, severity, and intensity of the destructive behaviors

Staged environment to teach members appropriate alternative response to severe destructive behaviors. Typically delivered in intensive outpatient, day treatment, or inpatient facility, depending on dangerousness of behavior

***CPT Definition of Time Spent with Patient that is Eligible for Reimbursement:**

Face to Face time for outpatient visits is reimbursable and includes:

1. Time spent with patient
2. Time spent with family
3. Time spent with patient and family

Activities such as review of records, arranging further services, communicating with other professionals (health care, teachers, etc.) and family are considered non-face to face services provided to the member. These may occur before or after the member visit. Providing these non-face to face services are included in the work for codes 97151 to 97158 and codes 0362T and 0373T. The non-face-to-face activities are not eligible for claims submission independent of face-to-face time. (CPT 2021).

REFERENCES

http://www.cdc.gov/ncbddd/birthdefects/DownSyndrome.html