

Medical Policy:

**Applied Behavioral Analysis Medical Necessity
Criteria Worksheet for Initiation of ABA Therapy**

Created: 07-27-12

Effective: 08-16-12

Reviewed/No Updates 1.28.13

Reviewed/No Updates 02.13.14

Reviewed/No Updates 02.12.15

Reviewed/No Updates 02.11.16

ABA Medical Necessity Criteria Worksheet for Initiation of ABA Therapy

1. The member has been diagnosed with Autism or a Pervasive Spectrum Disorder as defined by the most current edition of the DSM by a provider appropriate to make the diagnosis?
YES_____ NO_____
2. The member is 18 years old or less
YES_____ NO_____
3. The member has been appropriately assessed by an ABA Provider approved by the Plan and the treatment plan has been developed by a Board Certified Behavioral Analyst (BCBA or BCBA-D)
YES_____ NO_____
4. The assessment data have been used to develop a plan to address each behavior or skill. The plan must reflect stimulus response consequences for each skill.
YES_____ NO_____
5. The frequency, rate, symptom intensity or duration, or other objective measure of baseline levels of each target behavior or skill is recorded and used to evaluate the impact of interventions and need to modify methods, and to identify when to progress to more advanced skills.
YES_____ NO_____
6. Specific type, duration and frequency of interventions are tied to the function served by the specific target behaviors or skills. Instructional tactics must be selected based on the assessment of skills and be in accordance with generally accepted standards of practice.
YES_____ NO_____

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7. Parent, family and caregivers are trained and required to provide specific additional interventions with the goal of generalization of skills.

YES _____ NO _____

All 7 criteria above must be evaluated and met. Initial authorization is for up to 15 hours per week for up to 90 days. After 90 days an assessment will need to occur for continuation of ABA Treatment.

ABA Medical Necessity Criteria for Continuation of ABA Therapy - 90 Day

1. A 90 day re-evaluation has been completed by the ABA Provider and a report submitted to the Health Plan.

Yes _____ No _____

2. The member and family have been compliant with the treatment plan and at least 75% of the ABA Treatments have occurred.

YES _____ NO _____

3. Since the last review, the frequency of the target behavior has diminished or there is improvement in the targeted skill.

YES _____ NO _____

If the answer is No, there has been modification of the treatment plan or additional assessments have been conducted

YES _____ NO _____

If 180 days have passed since the last documentation of improvement, has there been a reassessment by the ABA Certified Therapist, consultations from other staff and professionals, interventions changed, and parents retrained on the changed approaches?

YES _____ NO _____

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All 3 of the above criteria must be evaluated and have at least 1 yes response. Continued authorization is for up to 15 hours per week for up to 90 calendar days.

Criteria for Termination of Applied Behavioral Analysis Therapy

1. The member no longer meets the initial 7 criteria for ABA Therapy
YES_____ NO_____
2. The BCBA Therapist recommends discontinuation due to:
 - a. The target behaviors or lacking skills that have an impact on development, communication, interaction with typically developing peers, family teachers or caregivers or adjustment to the settings in which the member functions have diminished such that the member can adequately participate in developmentally appropriate essential community activities. _____
 - b. The member has improved and the improvement is sustainable in the home, school or other natural environment or in a less intensive treatment setting. _____
 - c. After multiple reassessments and multiple alterations in the treatment plan, the target behaviors or targeted skills have not improved and are not likely to improve with further treatment. _____
YES_____ NO_____
3. After 180 days of beginning ABA Therapy or in any 180 day time period the member and/or family have not been compliant with the treatment plan provided by the ABA Provider. At least 30% of the ABA Therapy Sessions recommended in the treatment plan have not occurred. Exceptions may be made by the Health Plan if there are documented reasons for failure of

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4. treatment participation beyond the control of the family, guardians or caretakers.

YES _____ NO _____

5. After 365 calendar days and 3 re-evaluations and multiple alterations of the treatment, the ABA provider has not documented a decrease in the target behavior or improvement in the skill.

YES _____ NO _____

If any of the above criteria are answered YES by the Plan Reviewer the ABA Therapy will no longer be considered medically necessary and authorization for any further ABA Therapy may be denied by the Ventura County Health Care Plan.

A. **Attachments:** None

B. **History:**

- a. Reviewer/Author: Albert Reeves, MD Date: 07-27-12
- b. Committee Review: UM on 08-16-12 & QA on 08-28-12
- c. Reviewed/No Updates by: Albert Reeves, MD on 1.28.13
- d. Committee Review: UM on 02/14/13 & QA on 02/26/13
- e. Reviewed/No Updates by: Linda Baker, RN & Catherine Sanders, MD
- f. Committee Review: UM: February 13, 2014; QAC: February 25, 2014
- g. Reviewed/No Updates by: Faustine Dela Cruz, RN & Catherine Sanders, MD
- h. Committee Review: UM: February 12, 2015; QAC: February 24, 2015
- i. Reviewed/No Updates by: Faustine Dela Cruz, RN & Catherine Sanders, MD
- j. Committee Review: UM: February 11, 2016; QAC: February 23, 2016