New Directions may authorize ASD-related services only if all of the following criteria are met:

1. The member has a diagnosis of Autism Spectrum Disorder (ASD) and a recommendation for ABA treatment made as a result of an evaluation at a Michigan Approved Autism Evaluation Center (AAEC). If the member is located out of the state of Michigan, the diagnosis requires all evaluation components listed in the Michigan Blue out-of-state Multidisciplinary Evaluation Checklist (MEC).
   [Note: This criterion includes cases in which the member has a diagnosis of Autism Spectrum Disorder (ASD) from a qualified health care professional, as defined below, and has begun but not yet completed the AAEC evaluation or all the components listed in the MEC.]
   a. A “qualified health care professional” is a professional who can conduct the diagnostic evaluation. Such professional is typically one of the following: pediatric neurologist, developmental pediatrician, board-certified pediatrician, board-certified child psychiatrist, fully licensed child psychologist, or medical doctor experienced in the diagnosis of ASD
   b. Diagnostic evaluation with order / treatment recommendation for treatment includes: developmental and medical history, behavioral and cognitive evaluation, medical comorbidity, neurological evaluation, and autism specific assessments.

2. Member is within the age range specified in the applicable health plan’s member service plan description or in the state mandate for treatment.

3. The ABA services recommended do not duplicate or replicate services received in a member’s primary academic educational setting, or are available within an Individualized Education Plan (IEP) or Individualized Service Plan (ISP).

4. There is a reasonable expectation that a member is able to, or demonstrates the capacity to, learn and develop generalized skills to assist in his or her independence and functional improvements.

5. The recommended ABA treatment is directed toward bridging the gap between the member’s chronological and developmental ages with goals focused on ASD core deficits.

6. Treatment is provided at the least restrictive and most clinically appropriate environment to safely, effectively and efficiently deliver care.

7. Treatment intensity does not exceed the member’s functional ability to participate.

8. Hours per week requested are not more than what is required to achieve the goals listed in the treatment plan.

9. Treatment is clinically appropriate and designed to meet the individualized needs of the member with regard to type, frequency, intensity, extent, site and duration of services.

10. Treatment is required for reasons other than the convenience of the patient, parents/caregiver/guardian, or physician or other health care provider.

11. Treatment is not a substitute for non-treatment services addressing environmental factors, nor primarily for custodial or respite care.

12. ABA treatment is not more costly than an alternate service or services, which will reasonably likely produce equivalent diagnostic or therapeutic results for the patient.

13. ABA services are provided by a Board Certified Behavior Analyst (BCBA) or line therapist supervised by a BCBA.
14. A comprehensive medical record is submitted by the ABA provider documenting the course of ABA treatment that includes all of the following documentation:
   a. Initial assessment request with diagnostic evaluation
   b. Individualized treatment plan with measurable goals and objectives that clearly addresses the active symptoms and signs of the member’s core deficits of ASD, formulated based on current assessments with reasonable expectations of mastery within a six-month period. The treatment plan should document these areas:
      i. Adaptive; for example, toilet training, dressing, joint attention skills, or eating;
      ii. Communication; for example, targets related to receptive and expressive communication and social language;
      iii. Behavior; for example, reduction of problem behaviors such as operantly ruminating/vomiting, tantrum behavior, aggression, or self-injurious behavior
      iv. Social; for example, engaging in social play, engaging in appropriate eye contact, demonstrating setting-specific behaviors;
      v. Collected data, including additional testing such as ABLLS, VB-MAPP or other developmentally appropriate assessments, celeration charts, graphs, progress notes that link to interventions of specific treatment plan goals/objectives;
      vi. Documentation of treatment participants and staff, procedures and setting;
      vii. Clinical documentation that the ABA therapy is focused on active symptoms of ASD that inhibit daily functioning and that gains made through treatment close the current gap with the member’s functioning level and same age peers;
      viii. Parent participation at least 80 percent of scheduled parent training sessions. Parent training is defined as the education and development of parent-mediated ABA strategies, protocols, or techniques directed at facilitating, improving, or generalizing social interaction, skill acquisition and behavior management, to include observational measures for assurance of treatment integrity. It is recommended that one hour of parent 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 parent declines. Parent training requirements should increase to a higher ratio of total direct line therapy hours as increased number of 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 policy benefit restrictions. Parent 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. ABA principles utilized during parent training to achieve desired outcomes may include, but are not limited to, reinforcement, task analysis, prompting, fading, shaping and chaining;
      ix. Baseline Vineland testing within a 45-day period before or after the initial service start date;
      x. Transition and aftercare planning. Transition and aftercare planning should begin during the early phases of treatment. Planning should focus on the development of goals and treatments, as well as the identification of appropriate services and supports for the time period following ABA
treatment. The transition planning process and documentation should include active involvement and collaboration with a multidisciplinary team. Transition and aftercare goals must be developed specifically for the individual with ASD, be functional in nature, and focus on skills needed in current and future environments.

### Intensity of Service Criteria

**Comprehensive Treatment Requests**

Comprehensive treatment requests are typically up to 30 total hours of weekly treatment to include direct 1:1 ABA, parent training, supervision and treatment planning based on the member’s severity, intensity and frequency of symptoms.

Comprehensive ABA treatment targets members whose treatment plans address deficits in all of the core symptoms of Autism. Appropriate examples of comprehensive treatment include: early intensive behavioral intervention 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 a least restrictive environment and small group format. Parent training is an essential component of Comprehensive ABA treatment. 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.

**Focused Treatment Requests:**

Focused treatment requests are typically up to 15 total hours per week based on the member’s severity, intensity and frequency of symptoms, and may include parent training as the only component.

Focused treatment typically targets a limited number of behavior goals requiring substantial support. 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.

**Hours to be Authorized**

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

- The medical policy
- Provider treatment plan
- Member’s age
- Severity of symptoms, including aberrant behaviors
- Developmental functioning as indicated by psychological testing such as the Vineland

### Caseload Size
The Behavioral Analyst Certification Board’s (“BACB”) Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers, 2nd Edition, [page 35], 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, a BCaBA).

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

**Supervising Focused Treatment**
- Without support of a BCaBA is 10 - 15*
- With support of one (1) BCaBA is 16 - 24*

Additional BCaBAs 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 BCaBA is 6 - 12
- With support of one (1) BCaBA is 12 - 16

Additional BCaBAs permit modest increases in caseloads.

**Continued Stay Criteria**

New Directions may authorize ASD-related services only if all of the following criteria are met:

1. The member has a diagnosis of Autism Spectrum Disorder (ASD) and a recommendation for ABA treatment made as a result of an evaluation at a Michigan Approved Autism Evaluation Center (AAEC). If the member is located out of the state of Michigan, the diagnosis requires all evaluation components listed in the Michigan Blue out of state Multidisciplinary Evaluation Checklist.
2. Member is within the age range specified in the applicable health plan’s member service plan description or in the state mandate for treatment.
3. The ABA services recommended do not duplicate or replicate services received in a member’s primary academic educational setting, or are available within an Individualized Education Plan (IEP) or Individualized Service Plan (ISP)
4. There is a reasonable expectation that a member is able to, or demonstrates the capacity to, learn and develop generalized skills to assist in his or her independence and functional improvements.
5. The recommended ABA treatment is directed toward bridging the gap between the member’s chronological and developmental ages with goals focused on ASD core deficits
6. Treatment is provided at the least restrictive and most clinically appropriate environment to safely, effectively and efficiently deliver care.

7. Treatment intensity does not exceed the member’s functional ability to participate.

8. Hours per week requested are not more than what is required to achieve the goals listed in the treatment plan.

9. Treatment is clinically appropriate and designed to meet the individualized needs of the member with regard to type, frequency, intensity, extent, site and duration of services.

10. On concurrent review, the current ABA treatment demonstrates significant Improvement on treatment plan goals and progress toward bridging the member’s chronological and developmental ages.

   a. Significant improvement is: mastery of a minimum of 50 percent of stated goals and/or objectives found in the submitted treatment plan. This is demonstrated through pre- and post-data, including documented generalization of skills developed through goals across people, settings and environments.

   b. Evidence used to show member progress toward bridging the gap between chronological and developmental ages includes psychological tests such as the Vineland. The documentation must show evidence of measureable functional improvement, as opposed to declining or plateaued scores.

   c. For members who do not master 50 percent of stated goals and objectives and/or demonstrate evidence toward bridging the gap between chronological and developmental ages, the treatment plan should clearly address the barriers to treatment success. Psychological testing may be requested to clarify lack of treatment response. If on subsequent reviews the member does not demonstrate significant improvement or progress mastering goals and objectives, and/or progress toward bridging the member’s chronological and developmental ages, coverage of ABA services may be denied through the peer review process.

11. Treatment is required for reasons other than the convenience of the patient, parents/caregiver/guardian, or physician or other health care provider.

12. Treatment is not a substitute for non-treatment services addressing environmental factors, nor primarily for custodial or respite care.

13. ABA treatment is not more costly than an alternate service or services, which will reasonably likely produce equivalent diagnostic or therapeutic results for the patient.

14. ABA services are provided by a Board Certified Behavior Analyst (BCBA) or line therapist supervised by a BCBA.

15. A comprehensive medical record is submitted by the ABA provider documenting the course of ABA treatment that includes the following documentation:

   a. Initial assessment request with diagnostic evaluation

   b. Individualized treatment plan with measurable goals and objectives that clearly addresses the active symptoms and signs of the member’s core deficits of ASD, formulated based on current assessments with reasonable expectations of mastery within a six-month period. The treatment plan should document these areas:

      i. Adaptive; for example, toilet training, dressing, joint attention skills, or eating;

      ii. Communication; for example, targets related to receptive and expressive communication and social language;
iii. Behavior; for example, reduction of problem behaviors such as operantly ruminating/vomiting, tantrum behavior, aggression, or self-injurious behavior;

iv. Social; for example, engaging in social play, engaging in appropriate eye contact, demonstrating setting-specific behaviors;

v. Collected data, including additional testing such as ABLLS, VB-MAPP or other developmentally appropriate assessments, celeration charts, graphs, progress notes that link to interventions of specific treatment plan goals/objectives;

vi. Documentation of treatment participants and staff, procedures and setting;

vii. Clinical documentation that the ABA therapy is focused on active symptoms of ASD that inhibit daily functioning and that gains made through treatment close the current gap with the member’s functioning level and same age peers;

viii. Parent participation at least 80 percent of scheduled parent training sessions. Parent training is defined as the education and development of parent-mediated ABA strategies, protocols, or techniques directed at facilitating, improving, or generalizing social interaction, skill acquisition and behavior management, to include observational measures for assurance of treatment integrity. It is recommended that one hour of parent 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 parent declines. Parent training requirements should increase to a higher ratio of total direct line therapy hours as increased number of 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 policy benefit restrictions. Parent 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. ABA principles utilized during parent training to achieve desired outcomes may include, but are not limited to, reinforcement, task analysis, prompting, fading, shaping and chaining;

ix. Vineland testing every twelve months and within a 45-day period before or after the service request. The Vineland may be required every six months based on clinical progress. Other standardized psychological tests may be requested dependent on clinical information obtained during the course of ABA treatment;

x. Transition and aftercare planning. Transition and aftercare planning should begin during the early phases of treatment. Planning should focus on the development of goals and treatments, as well as the identification of appropriate services and supports for the time period following ABA treatment. The transition planning process and documentation should include active involvement and collaboration with a multidisciplinary team. Transition and aftercare goals must be developed specifically for the individual with ASD, be functional in nature, and focus on skills needed in current and future environments.
**Exclusion Criteria (not intended to be all-inclusive)**

The following services have insufficient or no evidence to support efficacy and do not meet medical necessity:

- Services that are purely academic and duplicate or replicate academic learning in a school setting;

- Services that are not congruent with the Autism Spectrum Disorder for Applied Behavior Analysis Medical Necessity Coverage Criteria and/or the Service Intensity Guidelines;

- Services that address or treat symptoms other than the core symptoms of Autism. For the purpose of this document the core symptoms of autism are defined as deficits in social communications and social interaction across multiple contexts and restricted, repetitive patterns of behavior, interests, or activities;

- Cognitive Therapy or retraining;

- Treatment that is considered to be investigational/experimental, including, but not limited to: Auditory Integration Therapy; Facilitated Communication; Floor Time (DIR, Developmental Individual-difference Relationship-based model); Higashi Schools/Daily Life; Individual Support Program; LEAP; SPELL; Waldon; Hanen; Early Bird; Bright Start; Social Stories; Gentle Teaching; Response Teaching Curriculum and Developmental Intervention Model; Holding therapy; Movement Therapy; Music therapy; Pet Therapy; Psychoanalysis; Son-Rise Program; Scotopic Sensitivity training; Sensory Integration training; Neurotherapy (EEG biofeedback); Gluten-free/Casein-free diets; Mega-vitamin therapy; chelation of heavy metals; Anti-fungal drugs for presumed fungal infection; Secretin administration;

- Respite, shadow, para-professional, or companion services in any setting;

- Personal training or life coaching;

- ABA services in residential facilities to replace or augment the internal behavioral health or ABA program;

- Custodial care with focus on activities of daily living - bathing, dressing, eating and maintaining personal hygiene, etc. - that do not require the special attention of trained/professional ABA staff;

- Any program or service performed in nonconventional settings (even if the services are performed by a licensed provider), including: spas/resorts; vocational or recreational settings; Outward Bound; and wilderness, camp or ranch programs.

**Exclusion Definitions:**

**Custodial Treatment:**

- Non-skilled, personal care
  - Examples include: help with activities of daily living, such as bathing, dressing, eating, getting in or out of a bed or chair, moving around, using the bathroom, preparing special diets, and taking medications

- Care designed for maintaining the safety of the member or anyone else
- Care with the sole purpose of maintaining and monitoring an established treatment program.

**Respite Care**: care that provides respite for the individual’s family or persons caring for the individual.

**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.

**Exclusions listed in this section are not all-inclusive. State mandates and the controlling health plan may have benefit limitation and exclusions not listed in this medical necessity coverage criteria.**