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 Autism Spectrum Disorder (ASD).

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. DSMV 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. Benefit coverage for behavioral therapies to treat symptoms of ASD is driven by individual state mandates. Health plans for which New Directions currently administers the ASD benefit may consider ABA to be experimental/investigational and therefore a non-covered service without a controlling state mandate. In addition, large self-funded accounts may provide a benefit for ABA in ASD. These are not typically subject to mandate language.

ABA is the behavioral treatment approach most commonly used with children with ASD. 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 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.

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:

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

### Medical Necessity

These criteria will be applied to all service requests received by New Directions Autism Resource Program.

New Directions defines “Medical Necessity” or “Medically Necessary” as health care services rendered by a provider exercising prudent clinical judgment, which are:

**A. Consistent with:**

1. The evaluation, diagnosis, prevention, treatment or alleviation of symptoms of an illness, disease or injury defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM)
2. Generally accepted standards of medical practice, as defined by credible scientific evidence published in peer-reviewed medical literature, which are generally recognized by the appropriate medical community, Physician Specialty Society recommendations and other relevant factors.

**B. Clinically appropriate and designed to meet the individualized needs of the patient with regard to type, frequency, extent, site and duration of services**

**C. Considered effective to improve symptoms associated with the patient’s illness, disease, injury or deficits in functioning**

**D. Provided at the least restrictive and most clinically appropriate service or level of care to safely, effectively, and efficiently meet the needs of the patient**

**E. Required for reasons other than the convenience of the patient, family/support system, physician or other health care provider**

**F. Not a substitute for non-treatment services addressing environmental factors**

**G. Not more costly than an alternative service or services, which are at least as likely to produce equivalent diagnostic or therapeutic results for the patient’s illness, disease or injury**

### Coverage Guidelines: Initial Service Request

New Directions may authorize ABA services for ASD only if all of the following 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.

2. Diagnostic evaluation with order / treatment recommendation for treatment includes:
   a. A detailed developmental and medical history, including medical records from prior clinicians
   b. Behavioral and cognitive evaluation
   c. Medical comorbidity
   d. Neurological evaluation
   e. Autism specific assessments
   f. Adaptive behavior assessment
   g. Other information that may be required per state mandate or health plan requirement

3. 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 TREATMENT ASSESSMENT

New Directions may authorize an ABA services assessment only if all of the following criteria are met:

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.

Note: Only CPT or HCPCS codes 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, a clinical psychologist is qualified to provide testing services.

INITIAL ABA SERVICE TREATMENT REQUEST

New Directions may authorize the initiation of ABA services for ASD only if all of the following criteria are met:

1. 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)
2. Approved treatment goals and clinical documentation must be focused on active ASD core symptoms and deficits that inhibit daily functioning. This includes a plan for stimulus and response Generalization in novel contexts.
3. 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.
4. Adaptive Behavior Testing such as the Vineland and ABAS testing within a 45-day period before or after the initial service start date.
5. For comprehensive treatment, the requested ABA services are directed toward reducing 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.

OR

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.

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

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

8. A comprehensive medical record is submitted by the Board Certified Behavior Analyst (BCBA) to include:
   a. All initial assessments performed by the BCBA. Preferred assessments include the ABLLS, VB-MAPP, and any other developmental measurements employed
   b. Individualized treatment plan with measurable goals that clearly address the active symptoms and signs of the member’s core deficits of ASD
   c. Goals should be written with measurable criteria such that they can be reasonably achieved within six months
   d. Goals should include: documentation of core symptoms of ASD in the treatment plan, date of treatment introduction, estimated date of mastery, and a specific plan for Generalization of skills
   e. Functional Behavior Assessment to address targeted problematic behaviors and provide data to measure progress, as clinically indicated
   f. Documentation of treatment participants, procedures and setting

9. Parent participation in 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.

10. Although not required for the initial service request, 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.

11. Direct line therapy services are provided by a line therapist, Registered Behavior Technician (RBT), or Board Certified Assistant Behavior Analyst (BCaBA), supervised by a BCBA or Doctoral level BCBA (BCBA-D), or provided in a manner consistent with the controlling state mandate. In selected circumstances, New Directions will consider direct 1:1 services provider by a BCBA or BCBA-D.

**Coverage Guidelines: Continued Service Request**

New Directions may authorize continued ABA treatment services for ASD only if all of the following criteria are met:

1. Diagnostic Criteria as set forth in the current DSM are met
2. 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)
3. Approved treatment goals and clinical documentation must be focused on active ASD core symptoms and deficits that inhibit daily functioning. This includes a plan for stimulus and response Generalization in novel contexts.
4. There is reasonable expectations of mastery of proposed goals within the requested six-month treatment period
5. 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
6. Adaptive Behavior Testing such as the Vineland and ABAS testing annually within a 45-day period before the next scheduled concurrent review. The Vineland or other standardized psychological tests may be required on any concurrent review dependent on clinical information obtained during the course of ABA treatment.
7. For comprehensive treatment, the requested ABA services are directed toward reducing 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. OR
   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.
8. Treatment intensity does not exceed the member’s functional ability to participate
9. Hours per week requested are not more than what is required to achieve the goals listed in the treatment plan
10. A comprehensive medical record is submitted by the BCBA to include:
a. 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
b. Individualized treatment plan with measurable goals that clearly address the active symptoms and signs of the member’s core deficits of ASD
c. Goals should be written with measurable criteria such that they can be reasonably achieved within six months
d. Goals should include documentation of core symptoms of ASD identified on the treatment plan, date of treatment introduction, estimated date of mastery, a specific plan for Generalization of skills, and the number of hours per week estimated to achieve each goal
e. Functional Behavior Assessment to address targeted problematic behaviors and provide data to measure progress, as clinically indicated
f. Documentation of treatment participants, procedures and setting

11. Parent participation in 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.

12. 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.

13. Direct line therapy services are provided by a line therapist, or RBT, or BCaBA, supervised by a BCBA or BCBA-D, or the provision of services is consistent with the controlling state mandate. In selected circumstances, New Directions will consider direct one to one services provider by a BCBA or BCBA-D.

14. On concurrent review, the current ABA treatment demonstrates significant Improvement on treatment plan goals and progress to develop or restore the function of the member:
a. Significant improvement is: mastery of a minimum of 50 percent of stated goals found in
the submitted treatment plan. Psychological testing may be requested to clarify
limited/lack of treatment response. Adaptive behavior, cognitive and/or language
testing must show evidence of measureable functional improvement, as opposed to
decreasing or plateaued scores.
b. For members who do not master 50 percent of stated goals and/or fail to demonstrate
measurable and substantial evidence toward developing or restoring the maximum
function of the member, the treatment plan should clearly address the barriers to
treatment success.
c. If the member does not demonstrate significant improvement or progress achieving
goals for successive authorization periods, benefit coverage of ABA services may be
reduced or denied.

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

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

**Service Intensity Classification**

Comprehensive treatments typically range from 30 to 40 total hours of weekly. However, 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 and frequency of symptoms. Comprehensive
treatment includes direct 1:1 ABA, parent training, supervision and treatment planning.

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 treatments typically range from 10 to 25 total hours per week. However, 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 and frequency of symptoms. This treatment 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 current medical policy and medical necessity
- Provider treatment plan, that identifies suitable behaviors for treatment and improves the functional ability across multiple contexts
- Member’s age
- Severity of symptoms, including aberrant behaviors
- Continued measurable treatment gains

**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.
DEFINITIONS:

- **Core deficits of Autism**: persistent deficits in social communication and social interaction across multiple contexts AND, restricted, repetitive patterns of behavior, interests, and activities

- **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 parent training strategy.

- **Baseline Data**: objective and quantitative measures of the percentage, frequency or intensity and duration of skill/behavior prior to intervention

- **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

- **Functional Analysis**: Empirically supported process of making systematic changes to the environment to evaluate the effects of the four testing conditions of play (control), contingent attention, contingent escape and the alone condition, on the target behavior, which allows the practitioner to determine the antecedents and consequences maintaining the behavior

- **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

- **Standardized Assessments**: the listed assessments are not meant to be exhaustive, but serve as a general guideline to measure intelligence, adaptive behaviors or provide diagnostic assessment

- **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

• **Interpersonal Care**: interventions that do not diagnose or treat a disease, and that provide either improved communication between individuals, or a social interaction replacement

• **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

**Autism Specific Assessments**
- Childhood Autism Rating Scale, second edition. (CARS-2)
- Childhood Autism Spectrum Test. (CAST)
- Social Communications Questionnaire (SCQ)
- Social Responsiveness Scale, second edition. (SRS-2)
- Autism Behavior Checklist (ABC)
- Gillian Autism Rating Scale (GARS)
- Aberrant Behavior Checklist
- Autism Diagnostic Observation Schedule, second edition. (ADOS-2)
- Autism Diagnostic Interview, revised. (ADI-R)
- Checklist for Autism in Toddlers (CHAT)

**Other Assessment Instruments**
- Vineland Adaptive Behavior Scale (VABS)
- Adaptive Behavior Assessment Scale (ABAS)

**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)

**Exclusions**

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 this medical policy
- Cognitive Therapy or retraining
- Services that address or treat symptoms other than the core symptoms of Autism
• 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. Benefit plans specifying the coverage of any treatment considered investigational/experimental are not subject to this exclusion

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

• Personal training or life and/or job coaching

• ABA services in residential facilities to replace or augment the facility’s behavioral health or ABA program

• Custodial care with focus on activities of daily living that do not require or have not responded to intensive ABA treatment staff: BCBA, BCBA-D, line therapist, RBT, etc.

• 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

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
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<tr>
<td>F84.0</td>
<td>Autistic Disorder</td>
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<tr>
<td>F84.3</td>
<td>Other Childhood Disintegrative Disorder</td>
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<tr>
<td>F84.5</td>
<td>Asperger Disorder</td>
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<tr>
<td>F84.8</td>
<td>Other Pervasive Developmental Disorder</td>
</tr>
<tr>
<td>F84.9</td>
<td>Pervasive Developmental Disorder, unspecified</td>
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</tbody>
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ABA Services that require two or more staff members will only be billed as one service provided by the rendering provider.

CPT Codes

0359T BEHAVIOR IDENTIFICATION ASSESSMENT

- Untimed single unit of service
- Conducted by BCBA or qualified health care professional
- Conducted face to face with member
- Obtain history of current and past behavioral functioning
- Review previous assessments and health records
- Interview parent/caregiver to further identify and define deficient adaptive or maladaptive behaviors
- Administer standardized and non-standardized test such as VB-MAPP, ABLLS, EFL
- Interpret test results
- Determine areas of need - development of treatment plan [plan of care] and “when warranted” instructions for line therapists to conduct follow-up assessments to study specific adaptive skills and problem behaviors. [These are reported under 0360T, 0361T, 0362T, and 0363T.]
- Code 0359T may be reported for the assessment required for early intensive behavioral intervention (EIBI)
- May be reported only once within a six-month interval

New Directions CPT Code Instructions: This code is used both for the initial ABA treatment assessment as well as for ongoing 6 month updated ABA treatment assessments. This is an untimed code.

0360T, 0361T OBSERVATIONAL BEHAVIORAL FOLLOW-UP ASSESSMENT

- Requires patient observation to evaluate severe impairments in the following:
  1. Communication: receptive and expressive language, echolalia, lack of pragmatic language, visual understanding, requests and labeling
  2. Social behavior: lack of empathy, lack of social reciprocity, little or no functional play skills cooperation, motivation, imitation, play and leisure, and social interactions
  3. Ritualistic and repetitive behaviors and self-injurious behaviors
Line Therapist completes under direction of BCBA, 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)

Administered single calendar day with follow-up time on other days

Time frame for completion is usually less than one month

IF BCBA completes, BCBA is considered a line therapist for billing purposes

New Directions CPT Code Instructions: This code is utilized for observation and data collection either for failure to show progress on treatment plan and/or for Functional Behavioral Assessments. 1 unit = 30 minutes.

0364T, 0365T ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL

- Administered by a single line therapist
- Face to face with one member
- BCBA or qualified health care provider directs treatment by:
  - Designing treatment plan goals and objectives
  - Analyzing data
  - Determining whether use of treatment goals and objectives is producing adequate progress

New Directions CPT Code Instructions: 1 unit = 30 minutes

0366T, 0367T GROUP ADAPTIVE BEHAVIOR TREATMENT

- Administered by a single line therapist
- Face to face with more than two members
- BCBA or qualified health care provider directs treatment by:
  - Designing treatment plan goals and objectives
  - Analyzing data
  - Determining whether use of treatment goals and objectives is producing adequate progress

New Directions CPT Code Instructions: 1 unit = 30 minutes

0368T, 0369T ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL MODIFICATION

- Administered by BCBA or qualified health care professional
- Face to face with a single member

New Directions CPT Code Instructions: This code is utilized for direct supervision activities with the member present. This includes the following activities:
  - Directly observe treatment implementation for potential program revision,
  - Monitor treatment integrity to ensure satisfactory implementation of treatment protocols
  - Directing staff and/or caregivers in the implementation of new or revised treatment protocols (client present)
Billing for the time of this activity is allowed only for BCBA or qualified health professional time even if other professional providers are present.
Indirect supervision activities including instructing technicians about the treatment protocol without the patient present are considered bundled into the direct reimbursement and cannot be billed separately*. The BACB recommends 2 hours of direct supervision per 10 hours of line therapy. 1 unit = 30 minutes.

0370T  FAMILY ADAPTIVE BEHAVIOR TREATMENT GUIDANCE

- Administered by BCBA or qualified health care professional
- Face to face with parents, guardian, and caregiver without members present
- Identify problem behaviors and deficits
- Teach parent, guardian and caregiver behavioral techniques to reduce maladaptive behaviors and skill deficits

New Directions CPT Code Instructions: 1 unit = 1 hour

0371T  MULTIPLE FAMILY GROUP ADAPTIVE BEHAVIOR TREATMENT GUIDANCE

- Administered by BCBA or qualified health care professional
- Face to face with parents, guardians and/or caregivers of multiple members without members present
- Teach parents, guardians and caregivers of multiple members behavioral techniques to reduce maladaptive behaviors and skill deficits

New Directions CPT Code Instructions: This code is typically used during the initial treatment phase to educate and orient families in ABA behavioral nomenclature and techniques. 1 unit = 1 hour

0372T  ADAPTIVE BEHAVIOR TREATMENT SOCIAL SKILLS GROUP-

- Administered by BCBA or qualified health care professional
- Monitor member’s social skill treatment plan goals/objectives and use behavioral techniques to work directly on identified skill deficits with other members in the group setting
- Service only reimbursable for members with direct participation in treatment protocol/interactions in order to meet their own individual treatment goals
- Maximum member per group - 8

New Directions CPT Code Instructions: 1 unit = 1 hour

0362T, 0363T  EXPOSURE BEHAVIORAL FOLLOW-UP ASSESSMENT

- On-site direction by BCBA, qualified health care professional
- Two or more line therapists assist in treatment protocol with supervision of BCBA, qualified health care professional
- BCBA/qualified health care professional shapes environmental or social contexts to examine triggers, events, cues, responses and consequences linked to maladaptive destructive behaviors, such as self-injurious actions, aggression, property destruction, pica or incessant yelling.
- Requires safe, structured environment with possible use of protective gear and padded room
New Directions CPT Code Instructions: 1 unit = 30 minutes. This code is utilized when completing a functional assessment.

**0373T, 0374T  EXPOSURE ADAPTIVE BEHAVIOR TREATMENT**

- 0373T is a one-hour unit, with 0374T (30-minute units) utilized after first hour
- Staged environment to teach members appropriate alternative response to severe destructive behaviors
- BCBA or qualified health care professional provides on-site supervision and direction of two or more line therapists
- Line Therapists collect data, keep member safe, and teach appropriate adaptive self-regulation and self-management skills
- Requires safe, structured environment with possible use of protective gear and padded room

These services are, “typically delivered in intensive outpatient, day treatment, or inpatient facility, depending on dangerousness of behavior,” per AMA CPT Assistant.

New Directions CPT Code Instructions: 1 unit = 30 minutes

**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

The non-face to face time (activities which may be occur before, during or after a visit) is included in the work for each CPT code reimbursement. These non-face to face activities are therefore not eligible for claims submission, independent of face to face time. These non-reimbursable events include such activities as: review of records, arranging further services, communicating with the professionals, the patient or the family through written reports and telephone contact, and other non-face to face activities.

REF: pg 8 of CPT Handbook 2016
REFERENCES


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