



Autism



BlueCross BlueShield
Kansas

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NOTE — The revision date appears in the footer of the document. Links within the document are updated as changes occur throughout the year.

I. Applied Behavior Analysts (ABA) Provider Network Eligibility & Enrollment

The following provider types may be eligible to enroll as a contracting provider with Blue Cross Blue Shield of Kansas (BCBSKS):

- LBA – Licensed Behavior Analyst
- BCBA – Board Certified Behavior Analyst
- BCBA-D – Board Certified Behavior Analyst, Doctorate
- LaBA – Licensed Assistant Behavior Analyst
- BCaBA – Board Certified Assistant Behavior Analyst
- AS – Autism Specialist
- RBT – Registered Behavioral Technicians
- IIS – Individual Intensive Support Provider

To determine eligibility LBA and LaBA provider types will have their license verified on the KSBSRB (Kansas Behavioral Sciences Regulatory Board) and must have a CAQH profile completed prior to submitting an enrollment request. The BACB (Behavior Analyst Certification Board) will be queried to verify certification for BCBA-D, BCBA, BCaBA, and RBT provider types. Autism Specialist and IIS provider types will submit a letter signed by the KDAS HCBS Autism Waiver Program Manager or HCBS Director.

Provider types BCBA-D, BCBA, and BCaBA who become licensed with the KSBSRB are asked to notify Provider Network Services (800-432-3587, Option 3) so that credentialing requirements can be met.

Any change of provider credentials should be immediately communication to BCBSKS. Please email update request and supporting documentation to prof.relations@bcbsks.com.

ABA providers interested in enrolling should submit the [provider network enrollment Request](#) for available at bcbsks.com to begin the enrollment process.

NOTE – Services provided by tutors, special education teachers, and paraprofessionals are not eligible under the Autism benefit.

II. Autism Spectrum Disorders Behavior Therapy Criteria

New Directions 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, and developmental disorder, characterized by three core deficit areas: social interactions, social communication, and restricted, repetitive patterns of behavior. For complete [BCBSKS NDBH Medical Coverage Criteria](#) and [BCBSKS Federal Employee Program NDBH Benefit Plan Coverage Criteria](#), go to ndbh.com.

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. 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 evaluation, 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 twice annually (frequency dependent upon the controlling state mandate) to allow re-assessment and to document progress in improving the gap between member's chronological and developmental age.

Coverage Guidelines

Authorization for ASD-related services may only be granted if all of the following criteria are met:

1. The member has a diagnosis of Autism Spectrum Disorder (ASD) from a clinician who is qualified to make such a diagnosis. Such clinicians are usually a Licensed Clinical Social Worker (LCSW), neurologist, developmental pediatrician, pediatrician, psychiatrist, licensed clinical psychologist, or medical doctor experienced in the diagnosis of ASD.
2. Diagnostic evaluation with order/treatment recommendation for treatment includes: developmental and medical history, behavioral and cognitive evaluation, medical co-morbidity, neurological evaluation, autism specific assessments, and other information that may be required by the member contract.
3. Member is within the age range specified within their member contract.
4. 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).
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. 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.
7. Treatment is provided at the least restrictive and most clinically appropriate environment to safely, effectively and efficiently deliver care.
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. 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.

11. 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 include psychological tests such as the Vineland. The documentation must show evidence of measurable 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.
12. Treatment is required for reasons other than the convenience of the patient, parents/caregiver/guardian, or physician or other health care provider.
13. Treatment is not a substitute for non-treatment services addressing environmental factors, nor primarily for custodial or respite care.
14. 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.
15. ABA services are provided by a BCBA or line therapist supervised by a BCBA/ AS, certified in Kansas.
16. 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 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 six 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 six months and within a 45-day period before the service request. 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.

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. Clinical Information includes submission of the Initial Treatment Plan form (available at <https://www.ndbh.com/Providers/Providers.aspx>) accompanied by the Diagnostic Evaluation that specifies a diagnosis of ASD, current Vineland scores, and any additional documentation of the member's condition (i.e., Early Intervention Services, IEP, pertinent medical records).

Service Intensity Classification

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 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:

- New Directions 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

Caseload size for the Behavior Analyst (BCBA/AS) 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

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

Supervising Focused Treatment

- Without support of a IIS/BCaBA is 10 to 15
- With support of a IIS/BCaBA is 16 to 24

Supervising Comprehensive Treatment

- Without support of a IIS/BCaBA is six to 12
- With support of a IIS/BCaBA is 12 to 16

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 (other than when provided as part of Applied Behavior Analysis services for eligible members) or retraining
- 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.
- Treatment that is considered to be investigational/experimental, including, but not limited to: Auditory Integration Therapy, Facilitated Communication, Floor Time (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, 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, academic, vocational or recreational settings; Outward Bound; and wilderness, camp or ranch programs

Exclusion Definitions

Custodial Treatment

1. 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
2. Care designed for maintaining the safety of the member or anyone else
3. 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.

III. Telehealth/Telemedicine

Telehealth/Telemedicine is not an approved method of service delivery for direct ABA services. Telehealth/Telemedicine for parent education and direct supervision activities can be covered if allowed as an eligible telehealth/telemedicine service under the member benefit plan. It is recommended that telehealth/telemedicine service delivery be combined with face-to-face service delivery of direct supervision activities.

All telemedicine services should be billed with place of service 02 and the GT modifier.

For more information, see [Policy Memo No. 2](#), VI. Telemedicine.

IV. General Billing Guidelines

All contracting providers who are defined as eligible providers under the member's BCBSKS contract and who are providing services as defined in their Kansas licensure or certification, shall bill their charges to BCBSKS under their own billing National Provider Identifier (NPI) or specific rendering provider number. For more information, see [Policy Memo No. 1](#).

Concurrent Care

BCBSKS does not allow concurrent billing of ABA services CPT 97153 and 97155 performed at the same time, on the same day for the same patient. Both services include adaptive behavior treatment and more than one practitioner will not be reimbursed for the same unit(s) of time. If a qualified health care professional is performing adaptive behavior treatment with protocol modification (97155) during part of the session time with line therapist, both practitioners could bill, if the start and stop times for each practitioner are clearly documented in the medical record and noted for each practitioner in the narrative on the claim form.

Autism Coding Guidelines

Code	Description	Details
97151	<p>BEHAVIOR IDENTIFICATION ASSESSMENT administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan.</p>	<ul style="list-style-type: none"> • 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) <p><i>May be reported only once within a six-month interval.</i></p>
97152	<p>BEHAVIOR IDENTIFICATION – SUPPORTING ASSESSMENT administered by one technician under direction of a physician or other qualified health care professional, face-to-face with the patient each 15 minutes.</p>	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ 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 and self-injurious behaviors • Line Therapist may complete 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) • Requires clinical rationale for need
97153	<p>ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL administered by a technician under the direction of a physician or other qualified health care professional, face-to-face with one patient each 15 minutes.</p>	<ul style="list-style-type: none"> • May be administered by a line therapist • Face to face with one member • BCBA or qualified health care provider directs service by: <ul style="list-style-type: none"> ○ Designing treatment plan goals and objectives ○ Analyzing data ○ Determining whether use of treatment goals and objectives is producing adequate progress

Code	Description	Details
97154	<p>GROUP ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL administered by a technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients each 15 minutes.</p>	<ul style="list-style-type: none"> • May be administered by a line therapist • Face to face with two or more members • BCBA or qualified health care provider directs service by: <ul style="list-style-type: none"> ○ 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 member per group - 8
97155	<p>ADAPTIVE BEHAVIOR TREATMENT WITH PROTOCOL MODIFICATION administered by a physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient each 15 minutes.</p>	<ul style="list-style-type: none"> • Administered by BCBA 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 BCBA or qualified health professional time even if other professional providers are present <p>The BACB recommends 2 hours of direct supervision per 10 hours of line therapy. Clinical rationale must be provided for requests that exceed the BACB recommendation for adaptive treatment by protocol modification</p>
97156	<p>FAMILY ADAPTIVE BEHAVIOR TREATMENT WITH GUIDANCE administered by a physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes.</p>	<ul style="list-style-type: none"> • Administered by BCBA 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	<p>MULTIPLE FAMILY GROUP ADAPTIVE BEHAVIOR TREATMENT GUIDANCE administered by a physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardian(s)/caregiver(s), each 15 minutes.</p>	<ul style="list-style-type: none"> • Administered by BCBA 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 member per group - 8 <p>This code is typically used during the initial treatment phase to educate and orientate families in ABA behavioral nomenclature and techniques.</p>
97158	<p>GROUP ADAPTIVE BEHAVIOR TREATMENT WITH PROTOCOL MODIFICATION administered by a physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes.</p>	<ul style="list-style-type: none"> • Administered by BCBA 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 member per group - 8

Code	Description	Details
0362T	BEHAVIOR IDENTIFICATION SUPPORTING ASSESSMENT, EACH 15 MINUTES OF TECHNICIANS' TIME FACE-TO-FACE WITH A PATIENT	<ul style="list-style-type: none"> • On-site direction by BCBA, qualified health care professional • With the assistance of two or more line therapists/ assistants to assist in treatment protocol with supervision of BCBA, 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 <p>Requires clinical rationale for need based on frequency, severity, and intensity of the destructive behaviors.</p> <p>BCBA/qualified health care professional shapes environmental or social contexts to examine triggers, events, cues, responses and consequences linked to maladaptive destructive behaviors</p>
0373T	ADAPTIVE BEHAVIOR TREATMENT WITH PROTOCOL MODIFICATION, EACH 15 MINUTES OF TECHNICIANS' TIME FACE-TO-FACE WITH A PATIENT	<ul style="list-style-type: none"> • On-site direction by BCBA, qualified health care professional • With the assistance of two or more line therapists/ assistants to assist in treatment protocol with supervision of BCBA, qualified health care professional • For member who exhibits destructive behavior (eg, 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 <p>Requires clinical rationale for need based on frequency, severity, and intensity of the destructive behaviors.</p> <p>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.</p>

Note – All ABA codes are billed in 15 minute units. "If the BCBA 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 technicians time to meet the components of the code ." AMA CPT, 2019

Revisions

01/01/2019	Redesigned manual.
	Pages 12-13 – Added telemedicine information.
	Pages 14-16 – Updated Autism Coding Guidelines.
03/01/2021	Page 3 – Updated ABA Provider Network Eligibility & Enrollment.
01/01/2022	Page 4 – Updated ABA Provider Network Eligibility & Enrollment section to reflect current practices.
	Page 9 – Updated General Billing Guidelines verbiage.
	Page 9 – Clarified Concurrent Care section
	Page 10 – Added section IV – General Billing Guidelines.



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