CURATIVE HEALTH PLAN

Medical Policy

Behavioral Health and Substance Use Disorder Services

Members Under 18 (Birth through Age 17)

Version 2.0

Policy Number	CHP-BEH-2026-001
Policy Title	Behavioral Health and Substance Use Disorder Services (Members Under 18)
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Applies To	Level Funded, Fully Insured, ASO
States	TX, FL, GA, DC, MD, IN, OH
Age Group	Under 18 (Birth through Age 17)
Version	2.0

SECTION 1: DISCLAIMER

The inclusion of a service, procedure, or CPT/HCPCS code in this medical policy does not constitute a guarantee of coverage or a benefit of the member's health plan. Coverage is determined by the terms of the member's specific benefit plan and certificate of coverage. This policy provides clinical criteria for medical necessity determination only. All services are subject to the terms, conditions, limitations, and exclusions of the member's benefit plan.

This policy is written for use by clinical reviewers and AI-assisted prior authorization systems. All criteria are intended to be applied by licensed healthcare professionals with expertise in behavioral health and child and adolescent psychiatry. Medical necessity determinations must be made on a case-by-case basis using all available clinical information.

This policy applies to Curative Health Plan commercial products only. It is not applicable to Medicaid, Medicare, or other government-sponsored programs unless expressly stated. State insurance mandates described in Section 7 apply *only to fully insured plans* subject to state regulation. Self-funded ERISA plans (ASO products) are generally exempt from state insurance mandates. Federal law, including the Mental Health Parity and Addiction Equity Act (MHPAEA), applies to all applicable commercial plan types (fully insured, self-funded, and level funded) regardless of state.

SECTION 2: POLICY STATEMENT

Curative Health Plan (CHP) provides coverage for behavioral health (BH) and substance use disorder (SUD) services for members under 18 years of age when such services are medically necessary, evidence-based, and delivered by qualified providers in appropriate clinical settings. This policy governs prior authorization requirements and medical necessity criteria for outpatient, intensive outpatient, partial hospitalization, and inpatient levels of care, including specialized services such as applied behavior analysis (ABA) therapy, behavioral health evaluations, transcranial magnetic stimulation (TMS), and electroconvulsive therapy (ECT).

Clinical criteria in this policy are grounded in the following frameworks and guidelines:

- *AACAP Practice Parameters* (American Academy of Child and Adolescent Psychiatry) — standard of care for pediatric psychiatric diagnosis and treatment
- *CALOCUS-CASII* (Child and Adolescent Level of Care Utilization System) — AACAP-endorsed level of care placement framework for ages 6–17
- *ECSII* (Early Childhood Service Intensity Instrument) — level of care framework for children birth through age 5
- *ASAM Criteria, 4th Edition (2023)* — for substance use disorder level of care placement across all ages
- *BACB Ethics Code for Behavior Analysts (2022)* and *BACB ABA Practice Guidelines* — Behavior Analyst Certification Board standards for applied behavior analysis
- *CASP ABA Practice Guidelines Version 3.0 (May 2024)* — Council of Autism Service Providers

- *AAP Clinical Report on Autism Management (2020)* — American Academy of Pediatrics
- *AACAP Practice Parameters for Autism* — Comprehensive assessment; family and school coordination
- *NASEM Evidence Base for ABA (2025)* — National Academies of Sciences, Engineering, and Medicine

2.1 ABA Therapy — Scope of Coverage

Curative Health Plan covers Applied Behavior Analysis (ABA) therapy for the treatment of Autism Spectrum Disorder (ASD) in members under 18 when services meet the medical necessity criteria set forth in Sections 4[Z] and 5[Z] of this policy. ABA is a discipline applying evidence-based behavioral principles to assess, reduce, and replace maladaptive behaviors while simultaneously teaching functional skills across communication, social, adaptive, and behavioral domains.

ABA therapy is recognized as medically necessary for qualifying members with ASD by the American Academy of Pediatrics (AAP), the American Academy of Child and Adolescent Psychiatry (AACAP), the National Academies of Sciences, Engineering, and Medicine (NASEM), the National Autism Center (NAC), and the Association for Behavior Analysis International (ABAI). The National Academies 2025 report concluded that ABA meets the standard of "reliable evidence of efficacy" across the lifespan.

2.2 MHPAEA Compliance Statement

ABA therapy is classified as a *mental health benefit* under the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008. Curative Health Plan is committed to MHPAEA compliance across all applicable commercial plan types. Accordingly:

1. *Quantitative Treatment Limitations (QTLs):* CHP does not apply annual or lifetime dollar caps, weekly hour caps, or age limits to ABA benefits for fully insured plans covered by MHPAEA, except where CHP has documented that equivalent limitations apply to comparable medical/surgical benefits under the same plan.

2. *Non-Quantitative Treatment Limitations (NQTLs):* CHP applies prior authorization and clinical criteria to ABA services in a manner comparable to the processes applied to analogous medical/surgical benefits. Clinical criteria that would function as NQTLs more restrictive than those for comparable medical/surgical services are not applied.

3. *Maintenance Coverage:* ABA services required to maintain function and prevent clinically significant deterioration constitute medically necessary treatment. Denial of continuation of ABA services based solely on absence of measurable improvement, without consideration of maintenance need or prevention of deterioration, is not consistent with MHPAEA requirements.

4. *Comparative Analysis:* CHP maintains NQTL comparative analyses as required by the Consolidated Appropriations Act (CAA) of 2021. These analyses are available to regulators and plan participants upon request.

Mental Health Parity and Addiction Equity Act (MHPAEA) compliance applies across all BH/SUD services in this policy: Coverage criteria, prior authorization requirements, and benefit limitations applicable to behavioral health and substance use disorder services shall not be more restrictive than those applied to analogous medical/surgical benefits within the same benefit classification. All non-quantitative treatment limitations (NQTLs) applied to BH/SUD services under this policy have been assessed for comparability to corresponding medical/surgical NQTLs as required by MHPAEA (29 U.S.C. § 1185a) and implementing regulations.

2.3 ASO vs. Fully Insured — State Mandate and Policy Criteria Applicability

Plan Type	State Mandate Applicability	CHP Policy Criteria Applicability	Federal Law Applicability
Fully Insured	State mandates APPLY (see Section 7); the more favorable of state mandate or this policy applies	CHP hour caps and supervision requirements apply; state mandate governs where more generous	MHPAEA applies
ASO (Self-Funded ERISA)	State mandates DO NOT apply (ERISA preemption)	Hour caps and supervision requirements as outlined in this policy DO apply	MHPAEA applies
Level Funded	Generally treated as self-funded under ERISA; state mandates typically DO NOT apply	Hour caps and supervision requirements of this policy apply	MHPAEA applies

For fully insured plans, CHP applies the more favorable rule: where a state mandate provides more generous coverage than the limits set forth in this policy, the state mandate governs. Where the state mandate imposes restrictions more stringent than this policy, MHPAEA parity analysis is applied before enforcing the state provision.

SECTION 3: APPLICABLE CPT/HCPCS CODES

3A. ABA Therapy Codes

CPT/HCPCS Code	Description	Qualified Provider	Unit
0362T	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: a) administration by two or more technicians; b) administered in an environment customized to the patient's behavior; c) completion in the context of a functional analysis with ongoing direction by a physician or other qualified health care professional	BCBA-D or BCBA (supervising, on-site); BCaBA/RBT (administering, two or more)	15-min units

CPT/HCPCS Code	Description	Qualified Provider	Unit
0373T	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: a) administration by two or more technicians; b) administered in an environment customized to the patient's behavior; c) completion in the context of a functional analysis with ongoing direction by a physician or other qualified health care professional	BCBA-D or BCBA (supervising, on-site); BCaBA/RBT (administering, two or more)	15-min units per technician
97151	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 non-face-to-face interpreting results and preparing reports	BCBA-D, BCBA, or licensed MH provider	15-min units
97152	Behavior identification supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes	BCaBA, RBT, or other technician under QHP direction	15-min units
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient; each 15 minutes	BCaBA, RBT, or qualified technician under BCBA supervision	15-min units
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients; each 15 minutes	BCaBA, RBT, or qualified technician under BCBA supervision	15-min units per patient
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient; each 15 minutes	BCBA-D, BCBA, or licensed MH provider (patient must be present)	15-min units
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present); each 15 minutes	BCBA-D, BCBA, or licensed MH provider	15-min units
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present); each 15 minutes	BCBA-D, BCBA, or licensed MH provider	15-min units per set of caregivers per patient
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients; each 15 minutes	BCBA-D, BCBA, or licensed MH provider	15-min units per patient

3A-1: Telehealth Delivery Rules — ABA Codes

Telehealth is PERMITTED for the following ABA codes:

Code	Telehealth Permitted	Notes
97151	*Yes*	Behavior identification assessment; face-to-face and indirect components
97155	*Yes*	Adaptive behavior treatment with protocol modification by QHP
97156	*Yes*	Family adaptive behavior treatment guidance
97157	*Yes*	Multiple-family group adaptive behavior treatment guidance

Telehealth is NOT PERMITTED — IN-PERSON DELIVERY REQUIRED for the following ABA codes:

Code	Telehealth Permitted	Clinical Rationale
97153	*No — in-person required*	Direct 1:1 technician treatment requires physical presence for hands-on behavioral intervention and data integrity
97154	*No — in-person required*	Group technician treatment requires physical co-presence of patients and technician
0362T	*No — in-person required*	Functional analysis of destructive behavior requires physical presence of QHP on-site, 2+ technicians, and customized environment
0373T	*No — in-person required*	Treatment of destructive behavior requires physical presence of QHP on-site and 2+ technicians for safety management

3A-2: Concurrent Billing Rules and Bundling — ABA Codes

Code Pair	Concurrent Billing	Conditions/Restrictions
97153 + 97155	*Permitted*	Patient present; QHP directing technician on modified protocol; time is separate and non-overlapping
97154 + 97155	*Permitted*	QHP directing technician during group treatment; distinct time blocks
97156 + 97153	*Permitted*	Patient receiving direct treatment elsewhere simultaneously; caregiver training occurring concurrently
97154 + 97158	*NOT Permitted*	Same session — cannot bill technician group and QHP group simultaneously for same patient group
0373T + 97155	*NOT Permitted*	Indirect services are bundled into 0373T; no separate 97155 billing
97151 + 97153/97155 (same day)	*Case-by-case*	Assessment and treatment may occur same day with distinct time documentation
97153 + 97155 (overlapping time)	*NOT Permitted*	The same unit of time cannot be billed under both codes simultaneously except as described above

Code Pair	Concurrent Billing	Conditions/Restrictions
Any code + same time block	*NOT Permitted*	No double-billing of overlapping time; each unit of time may only be billed under one code

Time Billing Rules — All ABA CPT Codes:

- All codes bill in *15-minute increments*
- CPT time rule: 8–22 minutes = 1 unit; fewer than 8 minutes = not reportable
- Face-to-face time only for all codes, *EXCEPT* `97151`, which includes both face-to-face and indirect (non-face-to-face) time
- `97151` is typically billed only at initial evaluation and reassessments — not weekly
- `97152` is typically capped at 8–32 units (15-minute increments) per assessment
- `0373T` billing = sum of all technician time (e.g., 3 technicians × 180 minutes = 36 units)
- Group codes `97154` and `97158` are subject to reasonable unit limits per week with clinical justification
- `0362T` and `0373T` (Category III) are limited to severely destructive behavior cases requiring continuous observation by 2+ technicians plus protocol modification

3B. Behavioral Health Evaluation Codes

CPT/HCPCS Code	Description	Provider Type
`90791`	Psychiatric diagnostic evaluation (without medical services)	Licensed MH provider (psychologist, LCSW, LMFT, LPC); non-physician only
`90792`	Psychiatric diagnostic evaluation with medical services	MD/DO (psychiatrist or physician) ONLY
`96112`	Developmental test administration and scoring by physician or other qualified health care professional, including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed, with interpretation and report; first hour	Physician, psychologist, or other QHP
`96121`	Developmental test administration and scoring — each additional hour (add-on to 96112)	Physician, psychologist, or other QHP
`96125`	Standardized cognitive performance testing per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	Physician, psychologist, or QHP

CPT/HCPCS Code	Description	Provider Type
96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision-making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	Physician or QHP
96131	Psychological testing evaluation services — each additional hour (add-on to 96130)	Physician or QHP
96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision-making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	Physician or QHP
96133	Neuropsychological testing evaluation services — each additional hour (add-on to 96132)	Physician or QHP
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes	Physician or QHP
96137	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (add-on to 96136)	Physician or QHP
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes	Technician under QHP supervision
96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (add-on to 96138)	Technician under QHP supervision
96146	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only	Automated platform (no provider supervision required during administration)

3C. TMS and ECT Codes

CPT/HCPCS Code	Description	Notes
90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management	First session includes mapping and setup

CPT/HCPCS Code	Description	Notes
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session	Each subsequent TMS delivery session
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management	Threshold re-determination required
90870	Electroconvulsive therapy (ECT); including necessary monitoring	ECT — each treatment session

3D. Inpatient BH/SA — Facility Revenue Codes (POS 21, 51, 55, 56, 58)

Revenue Code	Description
0101	Psychiatric — Inpatient (Intensive Care)
0114	Room and Board — Psychiatric — Semiprivate, Two Beds
0116	Room and Board — Psychiatric — Ward
0118	Room and Board — Psychiatric — Private (general classification)
0124	Room and Board — Rehabilitation — Semiprivate, Two Beds
0126	Room and Board — Rehabilitation — Ward
0128	Room and Board — Rehabilitation — Private (general classification)
0134	Room and Board — Detoxification — Semiprivate, Two Beds
0136	Room and Board — Detoxification — Ward
0138	Room and Board — Detoxification — Private (general classification)
0144	Room and Board — Other — Semiprivate, Two Beds
0146	Room and Board — Other — Ward
0148	Room and Board — Other — Private (general classification)
0154	Room and Board — Residential Treatment — Semiprivate, Two Beds
0156	Room and Board — Residential Treatment — Ward
0158	Room and Board — Residential Treatment — Private (general classification)
1001	Behavioral Health Treatments/Services — Milieu or Psychosocial

Place of Service Codes: 21 (Inpatient Hospital), 51 (Inpatient Psychiatric Facility), 55 (Residential Substance Abuse Treatment Facility), 56 (Psychiatric Residential Treatment Center), 58

(Non-Hospital Residential Treatment Facility)

3E. Inpatient BH/SA — Professional Codes (POS 21, 51, 55, 56, 58)

CPT/HCPCS Code	Description
90785	Interactive complexity (add-on to primary psychotherapy codes)
90791	Psychiatric diagnostic evaluation
90832	Psychotherapy, 30 minutes with patient
90834	Psychotherapy, 45 minutes with patient
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (add-on)
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (add-on)
90846	Family psychotherapy (without the patient present), 50 minutes
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (add-on)
90870	Electroconvulsive therapy (ECT)
90876	Psychotherapy for crisis; each additional 30 minutes (add-on to 90832–90838)
96121	Developmental test administration and scoring — each additional hour
96130	Psychological testing evaluation services — first hour
96131	Psychological testing evaluation services — each additional hour
96132	Neuropsychological testing evaluation services — first hour
96133	Neuropsychological testing evaluation services — each additional hour
96136	Psychological or neuropsychological test administration and scoring — physician/QHP, first 30 minutes
96137	Psychological or neuropsychological test administration and scoring — physician/QHP, each additional 30 minutes
96138	Psychological or neuropsychological test administration and scoring — technician, first 30 minutes

CPT/HCPCS Code	Description
96139	Psychological or neuropsychological test administration and scoring — technician, each additional 30 minutes
99232	Subsequent hospital care, per day — moderate complexity
G0407	Care management services for behavioral health conditions, first 20 minutes
G2074	Behavioral health care manager activities, in the first calendar month of the first episode of care
H0010	Alcohol and/or drug services; sub-acute detoxification (residential addiction program)
H0011	Alcohol and/or drug services; acute detoxification (residential addiction program)
H0017	Behavioral health; residential (hospital residential treatment program), without room and board, per diem
H0018	Behavioral health; short-term residential (non-hospital residential treatment program), without room and board, per diem
H0019	Behavioral health; long-term residential (non-hospital residential treatment program), without room and board, per diem
H0035	Mental health partial hospitalization, treatment, less than 24 hours
H0038	Self-help/peer services, per 15 minutes
H2012	Behavioral health day treatment, per hour
H2036	Alcohol and/or drug treatment program, per diem
S9484	Crisis intervention service, per hour

3F. Outpatient BH/SA — Facility Revenue Codes (POS 02, 22, 51, 55, 56, 57, 58)

Revenue Code	Description
0905	Other Diagnostic Services — Psychiatric
0906	Other Diagnostic Services — Psychological Testing
0912	Other Therapeutic Services — Psychiatric
0913	Other Therapeutic Services — Occupational Therapy (Behavioral Health)

Place of Service Codes: 02 (Telehealth — Patient Not in Health Care Facility), 22 (On Campus Outpatient Hospital), 51 (Inpatient Psychiatric Facility), 55 (Residential Substance Abuse Treatment Facility), 56 (Psychiatric Residential Treatment Center), 57 (Non-Residential Substance Abuse Treatment Facility), 58 (Non-Hospital Residential Treatment Facility)

3G. Outpatient BH/SA — Professional Codes (POS 02, 22, 51, 57, 58)

CPT/HCPCS Code	Description
H0004	Behavioral health counseling and therapy, per 15 minutes
H0005	Alcohol and/or drug services; group counseling by a clinician
H0012	Alcohol and/or drug services; substance abuse/chemical dependency education lecture/discussion, per session
H0013	Alcohol and/or drug services; substance abuse/chemical dependency education lecture/discussion, per hour
H0014	Alcohol and/or drug services; ambulatory detoxification
H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours per day and at least 3 days per week and is based on DSM criteria)
H0016	Alcohol and/or drug services; medical/somatic (medical intervention in ambulatory setting)
H0035	Mental health partial hospitalization, treatment, less than 24 hours
H2015	Comprehensive community support services, per 15 minutes
S9480	Intensive outpatient psychiatric services, per diem
90792	Psychiatric diagnostic evaluation with medical services (MD/DO only)

Place of Service Codes: 02 (Telehealth — Patient Not in Health Care Facility), 22 (On Campus Outpatient Hospital), 51 (Inpatient Psychiatric Facility), 57 (Non-Residential Substance Abuse Treatment Facility), 58 (Non-Hospital Residential Treatment Facility)

3H. Partial Hospitalization

CPT/HCPCS Code	Description
S0201	Partial hospitalization services, less than 24 hours, per diem

Place of Service Codes: 02 (Telehealth — Patient Not in Health Care Facility), 51 (Inpatient Psychiatric Facility), 58 (Non-Hospital Residential Treatment Facility)

SECTION 4: MEDICAL NECESSITY CRITERIA — MEETS CRITERIA

SECTION 4[Z]: APPLIED BEHAVIOR ANALYSIS (ABA) THERAPY FOR AUTISM SPECTRUM DISORDER

This section governs prior authorization and medical necessity review for ABA therapy codes 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, and 0373T for members under 18 with a diagnosis of Autism Spectrum Disorder. The primary clinical authorities for ABA criteria are the BACB Ethics Code for Behavior Analysts (2022) and the CASP ABA Practice Guidelines Version 3.0 (May 2024).

4[Z]-A: Universal Prerequisites

*ALL of the following criteria must be met for authorization of any ABA service (*97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T*):*

4[Z]-A.1 The member has a current, documented DSM-5-TR diagnosis of Autism Spectrum Disorder (ASD), ICD-10-CM code F84.0 (Autistic disorder), F84.5 (Asperger's syndrome), F84.8 (Other pervasive developmental disorders), or F84.9 (Pervasive developmental disorder, unspecified), as established by a qualified evaluating provider.

4[Z]-A.2 The ASD diagnosis was established through a comprehensive diagnostic evaluation conducted by a qualified provider, specifically one of the following: (a) developmental pediatrician; (b) board-certified child psychiatrist; (c) licensed child psychologist (PhD or PsyD); (d) licensed clinical neurologist with documented ASD assessment training; or (e) other physician (MD/DO) with documented expertise in ASD diagnosis and assessment.

4[Z]-A.3 The comprehensive diagnostic evaluation included at least one validated, standardized autism assessment instrument from the following list:

- Autism Diagnostic Observation Schedule, Second Edition (ADOS-2)
- Autism Diagnostic Interview-Revised (ADI-R)
- Childhood Autism Rating Scale, Second Edition (CARS-2)
- Diagnostic Interview for Social and Communication Disorders (DISCO)
- Other standardized instrument with established psychometric validity for ASD diagnosis

Note: Screening instruments alone (M-CHAT-R, ASRS, SCQ, STAT, ASQ, RITA-T) are NOT sufficient as the sole diagnostic basis. Validated screening results that prompted the comprehensive evaluation may be included in the clinical record but do not substitute for comprehensive evaluation.

4[Z]-A.4 — Diagnostic Evaluation Currency: The DSM-5-TR ASD diagnosis must be within *36 months* of treatment initiation. If the original diagnostic evaluation is older than 36 months at the time of the initial authorization request, a re-evaluation by a qualified provider is required before ABA services will be authorized. This re-evaluation must include use of a validated diagnostic instrument (ADOS-2 or ADI-R preferred; CARS-2 or equivalent acceptable). The 36-month currency requirement is applied to ensure clinical accuracy.

4[Z]-A.5 The member exhibits documented functional impairment in at least one of the following adaptive behavior domains:

- Social communication and interaction (including use of language or augmentative/alternative communication for social purposes)
- Adaptive behavior (daily living skills: self-care, domestic, community participation)
- Behavior regulation (presence of interfering behaviors: self-injurious behavior, aggression, property destruction, stereotypy, elopement, or ritualistic/restrictive behaviors that impair functioning)
- Communication (receptive or expressive language delays relative to developmental expectations)
- Academic or educational functioning

Functional impairment must be documented with specific, objective information (frequency counts, adaptive behavior assessment scores, caregiver/teacher reports with concrete behavioral examples) — general narrative descriptions without behavioral specificity are insufficient.

4[Z]-A.6 The member demonstrates a reasonable expectation of clinical benefit from ABA intervention, defined as: (a) potential for skill acquisition, (b) potential for reduction of maladaptive behaviors, (c) maintenance of current adaptive functioning to prevent clinically significant deterioration, or (d) generalization of previously acquired skills to new settings or conditions.

4[Z]-A.7 A BCBA-developed individualized Behavior Intervention Plan (BIP) or ABA Treatment Plan, containing all elements specified in Section 4[Z]-F, is present or will be developed upon authorization of the initial behavior identification assessment (97151).

4[Z]-A.8 ABA services are to be delivered by, or under the supervision of, a qualified provider meeting the credentialing standards set forth in this policy, including applicable state licensure requirements as specified in Section 7.

4[Z]-A.9 A physician prescription or referral for ABA services is present. (Required under Florida mandate § 627.6686, Ohio mandate § 3923.84, and CHP standard practice; strongly recommended for all states to support coordination of care.)

4[Z]-B: Treatment Intensity Tiers

ABA treatment intensity must be individualized based on comprehensive behavioral assessment by the supervising BCBA. Two evidence-based intensity tiers are recognized per CASP ABA Practice Guidelines Version 3.0 (2024) and AAP Clinical Report on Autism (2020):

Tier	Hours Per Week	Typical Indication	Key Characteristics
Focused ABA	10–25 hours/week	Older children (typically age 8+); adolescents; mild-to-moderate ASD presentations; members with specific, limited behavioral or skill targets rather than global developmental delays	Addresses specific, defined goals (e.g., functional communication improvement, discrete behavior reduction, social skills development); does not require intensive coverage across all developmental domains simultaneously

Tier	Hours Per Week	Typical Indication	Key Characteristics
Comprehensive ABA (EIBI)	26–40 hours/week	Young children (typically ages 2–7); early intensive behavioral intervention (EIBI); moderate-to-severe ASD presentations with global developmental delays; members requiring simultaneous intervention across multiple developmental domains	Evidence strongest for early intensive intervention; multiple treatment targets across communication, social, adaptive, and behavioral skill domains; EIBI research base supports ≥30 hours/week for at least 2 years to achieve clinically significant gains

Clinical Guidance on Intensity Determination:

1. Treatment intensity must be individually determined by the supervising BCBA based on comprehensive behavioral assessment — not by age, diagnosis date, or plan-level defaults.

2. A member's age alone does NOT determine intensity tier. An older child with global deficits across multiple domains may require comprehensive hours; a young child with specific, limited targets may appropriately receive focused hours.

3. As treatment goals are mastered, clinical step-down from comprehensive to focused intensity, and from focused intensity to discharge, is expected and should be reflected in updated treatment plans.

4[Z]-B1: Maximum Weekly Hour Limits

The following table reflects the upper limits applied under this policy and is consistent with the clinical evidence base. These are maximum limits, not entitlements or targets. Actual authorized hours are determined by individualized clinical assessment and documented medical necessity, and may be less than the maximums listed. Authorization of hours above these limits requires extraordinary clinical justification and is subject to heightened clinical review.

Treatment Type	Age	Maximum Hours/Week
Comprehensive ABA (EIBI)	2–7 years	Up to 40 hrs/wk
Comprehensive ABA	8–12 years	Up to 30 hrs/wk
Focused ABA	All ages	Up to 25 hrs/wk
School-age (during school year)	6–17 years	Typically not exceeding 20 hrs/wk during school hours unless documented school non-participation in services

Important Notes on Hour Limits:

- These are upper limits, not entitlements. Authorized hours must be clinically justified based on individualized assessment by the supervising BCBA.
- For school-age members (ages 6–17) during the school year, hours exceeding 20 per week require specific documentation that: (a) the member is not enrolled in or receiving school-based ABA services, or (b) the member's school does not provide services during

the relevant hours, or (c) extraordinary clinical need is present and documented.

• State mandate floors take precedence for fully insured plans where the state mandate provides more generous coverage. Maryland's minimum hour floors (25 hrs/week under age 6; 10 hrs/week ages 6–18) are minimum authorizations, not ceilings, and are not affected by the limits in this table.

• *MHPAEA Compliance:* These limits are applied as part of individualized prior authorization review — not as categorical maximum limits independent of medical necessity review. CHP does not apply these hour limits as hard caps without individualized clinical review.

4[Z]-C: Required Assessment Tools

The following assessment instruments are required at the stages indicated. Use of these instruments is supported by the CASP ABA Practice Guidelines Version 3.0 (2024) and the BACB Ethics Code.

4[Z]-C.1 — Diagnostic Confirmation (Required at Initial Authorization): The diagnostic evaluation supporting the ASD diagnosis must include at least one of the following validated diagnostic instruments:

• *Autism Diagnostic Observation Schedule, Second Edition (ADOS-2)* — required or strongly preferred for most age groups

• *Autism Diagnostic Interview-Revised (ADI-R)* — acceptable as the primary diagnostic instrument or in conjunction with the ADOS-2

> The ADOS-2 or ADI-R is required for diagnostic confirmation at initial authorization. Other instruments (CARS-2, DISCO, or equivalent) are acceptable where ADOS-2 and ADI-R are clinically inaccessible, with documented rationale.

4[Z]-C.2 — Norm-Referenced Adaptive Behavior Assessment (Required at Baseline and Every 6 Months):

• *Vineland Adaptive Behavior Scales, Third Edition (Vineland-3)* — required at: - Baseline (initial authorization, prior to or at onset of treatment) - Every 6-month reauthorization period as a standardized progress outcome measure - Vineland-3 results must be documented in the treatment plan and progress report with domain-specific composite scores

4[Z]-C.3 — Criterion-Referenced Skill Assessment (Required at Initial and Reauthorization): At least one of the following criterion-referenced behavioral/skill assessment instruments must be used to establish treatment targets and measure progress:

• *Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP)*

• *Assessment of Basic Language and Learning Skills-Revised (ABLLS-R)*

• *Assessment of Functional Living Skills (AFLS)*

Results from the selected criterion-referenced instrument must be used to establish specific, measurable treatment goals and to document progress at reauthorization.

4[Z]-C.4 — Functional Behavior Assessment (Required for Behavior Reduction Goals): When the treatment plan includes *behavior reduction goals* (targeting aggression, self-injurious behavior,

property destruction, elopement, stereotypy, noncompliance, or other interfering behaviors), a *Functional Behavior Assessment (FBA)* is required. The FBA must:

- Identify the antecedents, behaviors, and consequences (ABC) relevant to target behaviors
- Hypothesize the function(s) of the behavior (attention, escape, access to tangibles, sensory/automatic)
- Inform the development of function-based intervention strategies in the BIP
- Be updated when significant changes in behavior occur or when behavior reduction goals are modified at reauthorization

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4[Z]-D: Code-Specific Meets Criteria

4[Z]-D.1 — CPT `97151` (Behavior Identification Assessment by QHP)

> *MEETS CRITERIA when ALL of the following are true:*
> - *[97151-A]* The request is for a new behavior identification assessment required prior to initiating ABA treatment for a newly diagnosed member, OR the request is for a periodic reassessment following a change in diagnosis, significant change in clinical presentation, significant change in treatment response, or at the end of an authorization period (typically every 6 months).
> - *[97151-B]* The assessment is conducted by a BCBA-D, BCBA, or independently licensed mental health provider (physician, licensed psychologist, or other licensed provider credentialed by CHP as a QHP for ABA assessment purposes).
> - *[97151-C]* The assessment includes face-to-face time with the patient and/or guardian/caregiver AND non-face-to-face time for record review, scoring of standardized instruments, data analysis, report writing, and treatment plan development.
> - *[97151-D]* The assessment will result in (or updates) an individualized Behavior Intervention Plan or ABA Treatment Plan with specific, measurable, and individualized goals as described in Section 4[Z]-F.
> - *[97151-E]* The assessment uses validated behavioral assessment instruments as specified in Section 4[Z]-C, including Vineland-3 at baseline and each 6-month reassessment, and at least one criterion-referenced instrument (VB-MAPP, ABLLS-R, or AFLS).
> - *[97151-F]* `97151` is billed at initial evaluation and at periodic reassessments — not weekly or for routine daily/weekly treatment adjustments.
>
> Standard authorization parameters: Initial assessment up to 8 units (2 hours)/day; total initial assessment typically 24–32 units (6–8 hours); periodic reassessment typically 16–24 units. Additional units require clinical justification.

4[Z]-D.2 — CPT 97152 (Behavior Identification Supporting Assessment by Technician)

MEETS CRITERIA when ALL of the following are true:

- *[97152-A]* The supervising QHP (BCBA/BCBA-D) has determined that supplemental technician-based observational data collection is necessary to complete the behavior identification assessment.
- *[97152-B]* The QHP has reviewed the specific observation/data collection procedures with the technician prior to the session.
- *[97152-C]* The technician collects specific behavioral observation data (ABC data, interval recording, frequency/duration counts, scatterplot data, or other direct observational measures) that are directly reported to the QHP for interpretation.
- *[97152-D]* Only face-to-face technician time is billed; indirect time (data analysis, report preparation) is not billed under 97152 and is captured within the concurrent 97151 billing.
- *[97152-E]* The technician is operating under the real-time or prepared direction of the QHP.
- *[97152-F]* 97152 units billed do not exceed 8–32 units per assessment.

4[Z]-D.3 — CPT 97153 (Adaptive Behavior Treatment by Protocol — Technician, 1:1)

MEETS CRITERIA when ALL of the following are true:

- *[97153-A]* An active ASD diagnosis (ICD-10: F84.0, F84.5, F84.8, or F84.9) with current, authorized Behavior Intervention Plan is present.
- *[97153-B]* The treatment targets are measurable, individualized, observable, and documented in the current BIP.
- *[97153-C]* The technician (BCaBA or RBT) is implementing the approved BCBA-authored protocol as written, without modification (if protocol modification is required in the session, 97155 by the QHP is the appropriate code).
- *[97153-D]* The supervising BCBA maintains supervision documentation demonstrating a *minimum 10% supervision ratio* of the technician's direct treatment hours, with at least *two face-to-face supervision contacts per month* between the BCBA and the RBT, including direct observation of treatment by the BCBA during supervision sessions. Supervision time is billed separately under code 97155 and is not double-counted with direct treatment hours under 97153.
- *[97153-E]* Objective behavioral data is collected and documented for each treatment session, reflecting progress toward BIP goals.
- *[97153-F]* Active treatment has a realistic expectation of clinical benefit (skill acquisition, behavior reduction, maintenance of function, or generalization) for the member.
- *[97153-G]* Services are delivered *in-person*; 97153 is not billable via telehealth.

4[Z]-D.4 — CPT 97154 (Group Adaptive Behavior Treatment by Protocol — Technician, Group)

MEETS CRITERIA when ALL of the following are true:

- *[97154-A]* All criteria for 97153 (4[Z]-D.3 above) are met.
- *[97154-B]* The group consists of 2 to 8 patients receiving ABA services simultaneously.
- *[97154-C]* Clinical justification for group treatment format is documented, such as: social skills development targets benefiting from peer interaction; generalization training in social contexts; peer modeling as an evidence-based strategy for the member's specific goals.
- *[97154-D]* Each patient in the group has individualized behavioral goals that are appropriately addressed within the group treatment context.
- *[97154-E]* 97154 is not billed concurrently with 97158 for the same session and the same patient group.
- *[97154-F]* 97154 is billed per patient (not per group session).
- *[97154-G]* Services are delivered *in-person*; 97154 is not billable via telehealth.

4[Z]-D.5 — CPT 97155 (Adaptive Behavior Treatment with Protocol Modification — QHP with Patient)

MEETS CRITERIA when ALL of the following are true:

- *[97155-A]* The QHP (BCBA-D, BCBA, or licensed mental health provider with ABA training) is physically present (or present via approved telehealth) and face-to-face with the patient during the billed time.
- *[97155-B]* At least one of the following is occurring during the session: (a) the QHP is conducting direct 1:1 treatment with the patient and modifying protocol components (targets, reinforcers, prompting hierarchies, response measurement criteria, antecedent arrangements, consequence procedures) in real time; (b) the QHP is directing a technician on new or modified protocol components while the patient is present; (c) the QHP is directly observing patient-technician interaction and troubleshooting protocol implementation, with documented clinical rationale for observation in the session note.
- *[97155-C]* The session produces documented modifications, observations, or clinical decisions that are incorporated into the patient's BIP or session-specific protocol documentation.
- *[97155-D]* 97155 is not billed concurrently with 0373T.
- *[97155-E]* When 97155 is billed for BCBA supervision of RBT direct treatment, the time is separately documented from 97153 direct treatment time. Supervision time under 97155 counts toward the required 10% minimum monthly supervision ratio.

Note: When the QHP is simultaneously directing a technician implementing an unmodified protocol, 97153 may be billed concurrently for the technician's time. When the QHP is directing a technician on a modified protocol, 97155 is billed for the QHP's time; 97153 may also be billed for the technician's time.

4[Z]-D.6 — CPT 97156 (Family Adaptive Behavior Treatment Guidance — QHP)

MEETS CRITERIA when ALL of the following are true:

- *[97156-A]* The QHP (BCBA-D, BCBA, or licensed mental health provider) is conducting structured caregiver training directly related to the member's active ABA treatment plan.
- *[97156-B]* The training content addresses implementation of ABA-based procedures, including any of: reinforcement delivery systems, prompting and prompt-fading hierarchies, data collection procedures, behavioral management strategies, naturalistic teaching methods, functional communication training, antecedent modifications, or generalization/maintenance strategies.
- *[97156-C]* Training goals are documented in the member's BIP, with measurable caregiver competency targets.
- *[97156-D]* The training is designed to support implementation of the member's ABA program in natural environments (home, community, school).
- *[97156-E]* Patient presence is not required (may or may not be present).
- *[97156-F]* When the patient is simultaneously receiving direct ABA services (97153) in a separate location, 97156 may be billed concurrently.
- *[97156-G]* Caregiver training is provided at a frequency consistent with the mandatory caregiver participation requirements described in Section 4[Z]-G, with a minimum of 1–4 hours per month.

4[Z]-D.7 — CPT 97157 (Multiple-Family Group Adaptive Behavior Treatment Guidance — QHP)

MEETS CRITERIA when ALL of the following are true:

- *[97157-A]* All criteria for 97156 (4[Z]-D.6 above) apply.
- *[97157-B]* Two or more sets of guardian/caregiver groups are receiving training simultaneously from the QHP.
- *[97157-C]* The patient/member is NOT present during 97157 services (patient absence is required).
- *[97157-D]* Services are billed per set of caregivers per patient — not per individual caregiver attendee. If 5 families attend, 5 units per 15 minutes of group time are billable (one per family/patient).
- *[97157-E]* Group size does not exceed 8 caregiver groups per session.

4[Z]-D.8 — CPT `97158` (Group Adaptive Behavior Treatment with Protocol Modification — QHP, Group)

MEETS CRITERIA when ALL of the following are true:

- *[97158-A]* The QHP (BCBA-D, BCBA, or licensed mental health provider) is physically present and leading the group treatment session.
- *[97158-B]* The group consists of 2 to 8 patients.
- *[97158-C]* Clinical justification for QHP-led group format is documented.
- *[97158-D]* Each patient has individualized behavioral goals appropriately addressed within the group context.
- *[97158-E]* `97158` is not billed concurrently with `97154` for the same session and the same patient group.
- *[97158-F]* `97158` is billed per patient.

4[Z]-D.9 — CPT `0362T` (Behavior Identification Supporting Assessment — Destructive Behavior, Category III)

MEETS CRITERIA when ALL of the following are true:

- *[0362T-A]* The member exhibits severe destructive behavior, defined as one or more of: (a) self-injurious behavior (SIB) with potential for physical harm; (b) aggressive behavior directed toward others; (c) property destruction; (d) pica (ingestion of non-food items); (e) elopement/running behaviors with safety risk; (f) feeding difficulties with medical consequences; (g) sleep disturbance with health consequences; (h) rumination; (i) bruxism; (j) skin picking with tissue damage; (k) resistance to dental or medical care creating health risk.
- *[0362T-B]* A functional analysis (systematic manipulation of antecedent and consequence conditions to identify behavioral function) — as distinguished from a functional behavioral assessment (indirect/descriptive only) — is being conducted.
- *[0362T-C]* Two or more trained behavioral technicians are physically present throughout the session.
- *[0362T-D]* The environment has been customized and configured for the safety of the patient and technicians (padded surfaces, removal of dangerous objects, controlled stimulus presentation, configured escape conditions, etc.).
- *[0362T-E]* The QHP (BCBA-D or BCBA) is physically on-site throughout the assessment and is immediately available and interruptible to intervene or modify conditions.
- *[0362T-F]* Prior authorization for `0362T` services has been obtained before the session is conducted.
- *[0362T-G]* Services are delivered *in-person*; `0362T` is not billable via telehealth.

4[Z]-D.10 — CPT 0373T (Adaptive Behavior Treatment with Protocol Modification — Destructive Behavior, Category III)

MEETS CRITERIA when ALL of the following are true:

- *[0373T-A]* All criteria for 0362T (4[Z]-D.9 above) are met (destructive behavior documented; two or more technicians; customized environment; QHP on-site; preauthorized).
- *[0373T-B]* Active treatment of the destructive behavior is occurring, with protocol modification being implemented in real time.
- *[0373T-C]* The clinical necessity of multi-technician staffing for safety management during treatment is documented in the treatment plan and session notes.
- *[0373T-D]* Billing is calculated as the total accumulated time of all technicians combined (e.g., 3 technicians present for 3 hours = 9 total technician-hours = 36 units).
- *[0373T-E]* 0373T is not billed concurrently with 97155 for the same session (indirect services are bundled into 0373T).
- *[0373T-F]* Services are delivered *in-person*; 0373T is not billable via telehealth.

4[Z]-E: Supervision Requirements

Consistent with the BACB Ethics Code and CASP ABA Practice Guidelines, the following supervision requirements apply to all ABA services authorized under this policy:

4[Z]-E.1 — BCBA Supervision of RBT/Technician (Minimum Standard):

- Supervising BCBA must provide a minimum of *10% of the RBT's/technician's direct treatment hours* in supervision per month (this exceeds the BACB minimum of 5%)
- This equals typically 1–2 hours of supervision per 10 hours of direct treatment delivered
- Minimum *2 face-to-face supervision contacts per month* between the BCBA and the RBT are required
- *Direct observation of treatment* by the BCBA is required during supervision sessions; remote observation is not sufficient for all contacts — at least one contact per month must include in-person or synchronous real-time observation of the RBT delivering treatment to the patient
- Supervision time billed under 97155 separately from direct treatment hours billed under 97153; supervision hours and direct treatment hours may not be double-counted
- Supervision documentation must be maintained and available for audit, demonstrating compliance with the 10% minimum ratio

4[Z]-E.2 — BCaBA Supervision:

- BCaBA (Board Certified Assistant Behavior Analyst) supervision requirements are identical to RBT requirements above (minimum 10% monthly direct treatment hours supervised by BCBA; minimum 2 face-to-face contacts per month; direct observation required)
- *Additionally:* BCaBA must be supervised by a BCBA per current BACB standards; BCaBA may not practice independently without BCBA oversight

• BCaBA supervision documentation must reflect both the BCaBA's supervision of any RBTs under their oversight AND the BCBA's supervision of the BCaBA

4[Z]-E.3 — BCBA Supervisory Caseload:

• Authorization of hours that would exceed a BCBA's ability to maintain adequate supervision of the authorized caseload does not meet criteria. One BCBA cannot effectively supervise an unlimited number of RBTs while maintaining the 10% supervision standard. Requests for hours that exceed the BCBA's supervisory capacity as evidenced by supervision documentation will be flagged for clinical review.

4[Z]-F: Required Treatment Plan Elements

Initial Authorization: The following elements must be present in the BCBA-authored Behavior Intervention Plan (BIP) or ABA Treatment Plan submitted with or following the initial assessment authorization:

1. *Current ASD Diagnosis Documentation:* ICD-10 diagnosis code (F84.0, F84.5, F84.8, or F84.9); date of original diagnosis; diagnosing provider name and credentials; most recent comprehensive evaluation date and instruments used; confirmation that diagnostic evaluation is within 36 months of treatment initiation (per Section 4[Z]-A.4).

2. *Baseline Data:* Objective, quantitative baseline measurement for each behavioral target and skill acquisition program — expressed in measurable terms (e.g., frequency per hour, percentage of trials correct, duration in seconds, intensity rating, latency to response). Data must be collected prior to treatment initiation, not estimated. Vineland-3 baseline scores required per Section 4[Z]-C.2.

3. *SMART Goals:* Specific, Measurable, Achievable, Relevant, and Time-bound goals for each treatment target, including: - The specific skill or behavior targeted - The measurement method (frequency, rate, duration, percentage of opportunities, latency) - The mastery criterion — *minimum standard: 80% accuracy across 3 consecutive sessions*; higher criteria may be specified where clinically appropriate - The projected timeline for mastery - The clinical rationale for including the goal

4. *Evidence-Based Intervention Strategies:* Specific ABA-based intervention strategies identified for each goal, drawn from the NPDC/NAC evidence-based practice lists, including as appropriate: discrete trial training (DTT), natural environment teaching (NET), functional communication training (FCT), pivotal response training (PRT), differential reinforcement procedures, prompting and fading hierarchies, task analysis and chaining, video modeling, social narratives, and/or other specified evidence-based strategies.

5. *Treatment Intensity Justification:* Requested hours per week with clinical rationale tied to the member's individual presentation, number and complexity of treatment targets, and applicable evidence base for the intensity tier (Focused or Comprehensive). Hours requested must be consistent with the age-based limits in Section 4[Z]-B1 or include extraordinary clinical justification for any excess.

6. *Treatment Setting:* Clinic, home, or community setting with clinical rationale for the recommended setting(s). See Section 4[Z]-H for setting-specific requirements.

7. *Mandatory Caregiver Participation Plan:* Per Section 4[Z]-G, caregiver involvement in treatment is *mandatory*, not optional. The treatment plan must document: - Caregiver training goals with measurable caregiver competency targets - Planned frequency and format of 97156/97157 family guidance sessions (minimum 1–4 hours/month) - Measurable caregiver-implemented goals that the caregiver will carry out in natural environments - Plan for monitoring caregiver attendance (≥80% of scheduled sessions required) - Documentation of barriers to caregiver participation and accommodations offered, where applicable

8. *Generalization and Maintenance Plan:* Explicit strategies for promoting skill generalization across settings, people, and conditions; maintenance programming to support skill retention; natural environment training components.

9. *Supervision Structure:* BCBA supervision structure including supervision ratio (minimum 10% monthly hours per Section 4[Z]-E), format (direct observation required), and frequency — documenting compliance with supervision requirements.

10. *Coordination of Care Documentation:* Documentation of communication with and/or referral to: speech-language pathologist, occupational therapist, physical therapist, school/IEP team, primary care physician, and/or child psychiatrist, as applicable to the member's needs. If ABA and SLP/OT/PT are provided by the same agency, distinct treatment plans for each modality are required.

11. *Progress Measurement Methodology:* Data collection system described for each goal (e.g., trial-by-trial recording, event recording, partial/whole interval recording, momentary time sampling); data review schedule; criteria for plan modification.

12. *Discharge Criteria:* Explicit, measurable criteria defining when ABA services will be concluded or intensity reduced, tied to goal mastery, generalization, maintenance benchmarks, and demonstrated family/community independence.

13. *Required Assessment Tools Confirmation:* Documentation that Vineland-3, VB-MAPP/ABLLS-R/AFLS, and FBA (if applicable) have been administered per Section 4[Z]-C.

4[Z]-G: Mandatory Caregiver/Parent Involvement

Caregiver involvement in ABA therapy is *mandatory*, not optional, supported by the clinical evidence base establishing parent-mediated ABA as an evidence-based practice.

4[Z]-G.1 Caregiver participation in ABA treatment is required as a condition of continued authorization. The following standards apply:

- *Minimum frequency:* Caregivers must participate in a minimum of *1–4 hours per month* of caregiver training (billable under CPT 97156 or 97157) as a component of the member's authorized ABA program

- *Attendance standard:* Caregiver attendance/participation must be documented at *≥80% of scheduled caregiver training sessions* per authorization period
- *Measurable goals:* The treatment plan must include at least one measurable caregiver-implemented goal — a skill or behavior reduction strategy the caregiver implements in natural settings, with caregiver competency data collected

4[Z]-G.2 — Documentation of Caregiver Participation: Provider session notes and the treatment plan update must document:

- Whether the caregiver attended each scheduled `97156`/`97157` session (present/absent)
- The caregiver's progress on implementing ABA strategies in natural settings
- Caregiver competency data for measurable caregiver-implemented goals
- Barriers to caregiver participation (if applicable) and accommodations offered

4[Z]-G.3 — Failure to Meet Caregiver Participation Threshold:

- If caregiver attendance falls below 80% of scheduled sessions, the provider must first document the barriers encountered and accommodations offered to support participation
- Where barriers are identified (work schedule, transportation, language, disability), documented accommodations (schedule flexibility, telehealth sessions for caregiver training, interpreter services) must be attempted before any reduction in authorization is considered
- If, after good-faith effort and documented accommodation, the caregiver participation threshold (≥80%) continues not to be met without clinically acceptable justification, continued ABA authorization may be subject to reduction or non-authorization of the caregiver training component
- Failure of caregiver participation alone is *NOT* grounds for termination of the member's entire ABA program. The clinical impact of reduced caregiver involvement on the member's treatment plan must be individually assessed.

4[Z]-G.4 — MHPAEA Compliance: CHP applies caregiver participation requirements as a clinical standard of care rather than an absolute condition of authorization. CHP evaluates MHPAEA compliance in the application of caregiver participation requirements and maintains comparative analysis documentation confirming that equivalent standards are applied to comparable medical/surgical benefits.

4[Z]-H: Setting Requirements

4[Z]-H.1 — Covered Settings: The following treatment settings are covered when clinically indicated and documented in the treatment plan with clinical rationale:

- *Home:* Home-based ABA for domestic daily living skills, caregiver training, and natural environment teaching
- *Clinic/Center:* Clinic or ABA center-based treatment for structured skill acquisition programs
- *Community:* Community-based ABA (grocery store, playground, library) for generalization training in natural settings, with documented clinical justification for community setting goals

4[Z]-H.2 — School-Based ABA During School Hours:

- ABA delivered *during school hours* to a child *enrolled in and receiving school-based ABA services* through their IEP is *NOT covered* under this policy — such services are the responsibility of the school district under the Individuals with Disabilities Education Act (IDEA).
- ABA delivered during school hours to a child who is *not enrolled in or receiving school-based ABA services* through an IEP may be covered with documentation that the school is not providing ABA services during those hours and that the insurance-funded ABA addresses non-duplicative goals.
- ABA delivered *outside of school hours* (before school, after school, weekends) is not affected by this provision and may be covered when medically necessary.
- CHP does not categorically exclude all school-based ABA — the exclusion is specific to services that duplicate what the school is obligated to provide under IDEA/IEP.

4[Z]-H.3 — Telehealth: Code-specific telehealth rules apply as described in Section 3A-1. In summary:

- Billable via telehealth: `97151`, `97155`, `97156`, `97157`
- Requires in-person delivery: `97153`, `97154`, `0362T`, `0373T`

4[Z]-I: Progress Requirements

4[Z]-I.1 — Goal Mastery Criteria: Each treatment goal in the BIP must specify the mastery criterion. The minimum accepted mastery standard is *80% accuracy across 3 consecutive sessions* with at least 2 different therapists and in at least 2 different settings or conditions, unless documented clinical rationale supports a different criterion. Higher accuracy thresholds or additional generalization probes may be required for specific goals.

4[Z]-I.2 — Stagnation Policy: If, after *6 months* of ABA services with appropriate and documented plan revisions, there is no measurable progress on the *majority of active goals*, the clinical record must address why continuation of ABA is medically necessary. Lack of measurable progress alone does not automatically result in denial; the following must be individually evaluated per MHPAEA requirements:

- Whether the lack of progress is attributable to modifiable factors (e.g., inadequate supervision, insufficient caregiver participation, need for plan revision)
- Whether the member's condition would deteriorate without continued treatment (maintenance need)
- Whether ongoing behavioral safety needs require continued ABA regardless of skill acquisition progress
- If, after individualized review, continued ABA does not meet medical necessity given the above considerations, a plan-of-care conference with the BCBA and family is required before discontinuing services

4[Z]-I.3 — Required Outcome Measures Every 6 Months: At each 6-month reauthorization, the following outcome measures must be submitted:

- *Vineland Adaptive Behavior Scales, Third Edition (Vineland-3):* Required — provide current domain and composite scores compared to baseline and prior-period scores
- *At least one criterion-referenced measure:* VB-MAPP, ABLLS-R, or AFLS — provide current skill acquisition data compared to baseline and prior-period data
- Objective behavioral data for all behavior reduction targets (frequency, intensity, duration as applicable)

4[Z]-I.4 — Discharge Criteria: ABA services should be discharged or stepped down to a lower intensity when:

- Treatment goals have been mastered (per 4[Z]-I.1 mastery criteria)
- Mastered skills have been demonstrated with *generalization* across settings, people, and conditions
- *Family/community independence* in implementing strategies has been achieved and documented
- The member's adaptive functioning level no longer requires BCBA-supervised intervention to maintain

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4[Z]–J: Reauthorization Criteria

Authorization periods for ABA services are:

- *Initial authorization:* 6 months
- *Reauthorization periods:* 6 months

Formal reassessment by the supervising BCBA is required at a minimum of every 6 months. Reassessment must include administration of the Vineland-3 and at least one criterion-referenced instrument (VB-MAPP, ABLLS-R, or AFLS) per Section 4[Z]-C.

ALL of the following must be documented for reauthorization:

4[Z]-J.1 A Progress Summary Report containing objective behavioral data comparing baseline to current performance for each active goal, with visual data displays (graphs) strongly preferred. The progress summary must address:

- *Mastered goals:* Skills or behaviors that have met mastery criteria, with mastery date, generalization data, and maintenance probes
- *Active goals:* Current performance data versus baseline; projected mastery timeline
- *Modified goals:* Rationale for goal modification based on data
- *New goals:* Baseline data for newly added targets

4[Z]-J.2 Medical necessity for continuation is established by documenting at least one of the following:

- Continued skill acquisition toward independence in targeted domains, with data demonstrating progress
- Maintenance of acquired skills to prevent clinically significant deterioration (maintenance need is a valid medical necessity basis independent of measurable improvement)
- Ongoing reduction of maladaptive behaviors that impair functioning or pose safety risk
- Generalization training to extend previously acquired skills to new settings, people, or conditions
- Transition planning for educational or post-secondary environments (ages 14+)

> MHPAEA Compliance Note: Denial of reauthorization based solely on the absence of measurable improvement, without consideration of whether the member's condition would deteriorate without treatment, is not consistent with MHPAEA parity requirements.

4[Z]-J.3 An updated Behavior Intervention Plan reflecting:

- Revised goals (new baselines, updated targets, mastery criteria adjustments)
- Updated intervention strategies based on data review
- Updated treatment intensity recommendation with clinical justification (may step down if goals mastered)
- Continued or revised coordination of care documentation
- Updated Vineland-3 and criterion-referenced assessment results (per Section 4[Z]-C)
- Current caregiver-implemented goals and caregiver participation data

4[Z]-J.4 Caregiver engagement documentation demonstrating:

- Caregiver attendance rate at scheduled `97156`/`97157` sessions (target ≥80%)
- Progress on caregiver-implemented goals
- Documentation of barriers and accommodations if attendance was below threshold
- Updated caregiver competency data

4[Z]-J.5 Updated coordination of care statement noting changes in school placement, IEP services, speech/OT/PT services, psychiatric medications, or other relevant concurrent services.

4[Z]-J.6 Where required by state mandate or CHP clinical standards, an updated physician review/prescription for continued ABA services.

4[Z]-J.7 Treatment plan updates at 6-month reauthorization must specifically include:

- Progress on each goal with quantitative data
- New goals added and/or discontinued, with rationale
- Hour utilization versus authorized hours (to identify under- or over-utilization)
- Caregiver training completion rates
- Plan for transition/discharge with projected timeline

4[Z]-K: Age-Specific Criteria (Under 18 Focus)

Ages Under 8 Years — Early Intensive Behavioral Intervention (EIBI)

4[Z]-K.1 Early intervention ABA, including EIBI, is indicated and may be authorized at comprehensive intensity (26–40 hours/week; maximum 40 hours/week for ages 2–7 per Section 4[Z]-B1) when:

- ASD diagnosis is confirmed by comprehensive evaluation (ADOS-2 and/or ADI-R required for this age group per Section 4[Z]-C.1)
- Global developmental delays documented across two or more domains (social communication, language, adaptive behavior, play, cognitive functioning)
- Clinical assessment by supervising BCBA supports comprehensive intensity
- Vineland-3 baseline administered (per Section 4[Z]-C.2)

4[Z]-K.2 For children under age 3, ADOS-2 Toddler Module or equivalent toddler-validated instrument is recommended for diagnostic evaluation. ABA may be initiated based on DSM-5-TR diagnostic criteria met through validated instruments, with diagnostic reevaluation as clinically indicated as the child develops.

4[Z]-K.3 Comprehensive ABA for young children must include explicit caregiver training goals, as parent-mediated ABA delivery in natural environments (home, community) is an evidence-based component of EIBI programs. Minimum 1–4 hours/month of `97156` family guidance is required per Section 4[Z]-G.

4[Z]-K.4 School coordination documentation is required for children enrolled in Early Intervention (Part C) or special education (Part B) programs. ABA services must not duplicate services the school is obligated to provide under IDEA/IFSP/IEP.

Ages 8–17 Years — School-Age and Adolescent ABA

4[Z]-K.5 Focused ABA (10–25 hours/week) is most commonly indicated for school-age children and adolescents; however, comprehensive hours remain appropriate when global developmental delays persist across multiple domains. Maximum hours for ages 8–12 are up to 30 hours/week (Comprehensive) per Section 4[Z]-B1.

4[Z]-K.6 School coordination documentation is required. The treatment plan must address non-duplication of IEP-mandated services. ABA goals should complement (not duplicate) school-provided services.

4[Z]-K.7 For school-age members during the school year, hours above 20 per week require specific documentation per Section 4[Z]-B1 regarding school enrollment status and non-participation in school-based services.

4[Z]-K.8 Transition planning goals are appropriate beginning at age 14 (or earlier when clinically indicated), targeting: vocational preparation, independent living skills, community safety, social skills for employment, and post-secondary education support.

> Note: ABA for members ages 18–21 and 22+ is addressed in the separate adult policy (CHP-BEH-2026-002 or applicable adult BH policy). This Under 18 policy focuses on members under age 18 (birth through age 17). State mandate considerations for transition-age members approaching 18 are addressed in Section 7.

4[Z]-L: Concurrent Services

Speech-Language Pathology (SLP), Occupational Therapy (OT), and Physical Therapy (PT) are covered concurrently with ABA when all of the following conditions are met:

4[Z]-L.1 Each service (ABA, SLP, OT, PT) addresses *distinct, non-overlapping goals*. The treatment plans for each discipline must document the specific goals addressed by that discipline and how they differ from the goals of concurrent services.

4[Z]-L.2 Simultaneous billing during overlapping time is not permitted. If a member receives ABA and SLP simultaneously in the same time block, only one service may be billed for that time period.

4[Z]-L.3 Coordination among providers is required and must be *documented quarterly* in each service's treatment record. Coordination documentation must include:

- Communication with all concurrent service providers
- Summary of each provider's current goals and the member's progress
- Confirmation of non-duplication of services

4[Z]-L.4 If the *same agency* provides both ABA and SLP/OT/PT, *distinct treatment plans* for each modality are required, authored by the appropriate licensed provider for each discipline. Combined or overlapping plans do not satisfy this requirement.

4[Z]-L.5 At initial authorization and at each reauthorization, the provider must document the concurrent services the member is receiving and confirm that ABA goals are distinct from SLP/OT/PT goals.

4A. BEHAVIORAL HEALTH EVALUATIONS (Codes: 90791, 90792, 96112, 96121, 96125, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146)

4A.1 Psychiatric Diagnostic Evaluations (90791 and 90792)

90791 — *Psychiatric Diagnostic Evaluation (Non-Medical, Non-Physician):*

The following criteria must ALL be met:

1. The member presents with new, worsening, or significantly changed psychiatric symptoms requiring formal diagnostic evaluation.

2. The evaluation is conducted by an appropriately licensed mental health provider (licensed psychologist, LCSW, LMFT, LPC, or equivalent) who is not an MD or DO. (MD/DO providers must use 90792.)

3. The evaluation includes ALL of the following components: a. Comprehensive psychiatric history including developmental history, family psychiatric history, and prior treatment history b. Mental status examination c. Assessment of the child or adolescent in the context of family, school, and community (AACAP standard for pediatric evaluations) d. Informant reports from parents/guardians and teachers/school personnel where developmentally

appropriate e. Differential diagnosis f. Preliminary treatment plan or recommendations

4. Acceptable indications include: a. New psychiatric presentation requiring diagnostic clarification b. Return to care after significant lapse (typically >12 months without treatment) c. Significant change in condition requiring reassessment d. Second opinion evaluation

5. Pediatric evaluations may be completed across multiple sessions on separate dates of service when clinically necessary (e.g., separate child interview, parent interview, teacher informant), provided each session's medical necessity is documented.

`90792` — *Psychiatric Diagnostic Evaluation with Medical Services (MD/DO Only):*

The following criteria must ALL be met:

1. The evaluation is performed by a psychiatrist, child and adolescent psychiatrist, or other MD/DO.

2. The evaluation includes a medical assessment component in addition to the psychiatric evaluation, including: a. Review of medical history and physical findings relevant to psychiatric presentation b. Mental status examination c. Consideration of medical differential diagnoses d. Medication evaluation, initiation, or management considerations

3. Indication criteria are identical to `90791` above (criteria 3–5), with the additional requirement that medical services are clinically indicated as part of the evaluation.

4. `90791` and `90792` shall not be billed by the same provider on the same date of service.

4A.2 Psychological and Neuropsychological Testing

`96112` *and* `96121` — *Developmental Testing:*

1. The member presents with concerns regarding developmental milestones, adaptive behavior, cognitive development, or social/emotional development requiring formal standardized assessment.

2. `96112` is appropriate for assessment of: motor skills, language, cognitive level, social development, memory, and/or executive functions using standardized developmental instruments (e.g., Bayley-4, Vineland-3, BASC-3).

3. `96121` is an add-on code for each additional hour beyond the first.

4. This code is appropriate for developmental assessments and is distinct from neuropsychological testing (`96132`/`96133`); provider selects the code appropriate to the type of testing performed.

`96130`/`96131` *and* `96132`/`96133` — *Psychological and Neuropsychological Testing Evaluation:*

1. Testing is medically necessary for at least one of the following: a. Diagnostic clarification of suspected psychiatric disorder(s) and associated functional impairment b. Assessment of treatment response or need for change in treatment plan c. Evaluation of suspected developmental or neurodevelopmental disorder (ASD, intellectual disability, learning disorder, ADHD) d. Assessment of cognitive deficits including memory, attention, executive

function, language, or visuospatial processing e. Evaluation of cognitive impact of neurological condition, TBI, or medical illness f. Pre-treatment cognitive baseline when clinically indicated

2. Testing uses standardized instruments with established national normative data (not informal assessment or practitioner-developed tools).

3. 96130 and 96132 are mutually exclusive in the same testing episode. Provider selects the code that represents the predominant type of evaluation performed.

4. Evaluation codes (96130, 96131, 96132, 96133) must be billed with corresponding test administration codes (96136/96137 or 96138/96139, or 96146).

5. Authorization is typically limited to once per calendar year per testing type. Additional testing episodes require documented medical necessity justification.

96136/96137 — *Test Administration by Physician or QHP:*

1. Physician or qualified health care professional directly administers and scores two or more tests.

2. 96136 covers first 30 minutes; 96137 is add-on for each additional 30 minutes.

3. Must be billed with corresponding evaluation code (96130/96131 or 96132/96133).

96138/96139 — *Test Administration by Technician:*

1. Testing is administered and scored by a trained technician under the supervision of a qualified health care professional (physician or psychologist).

2. Technician may administer and score tests; all interpretation and evaluation services are performed by the supervising QHP.

3. 96138 covers first 30 minutes; 96139 is add-on for each additional 30 minutes.

96125 — *Standardized Cognitive Performance Testing:*

1. Testing involves a specific standardized cognitive performance test.

2. Billed per hour of QHP time, including administration, interpretation, and report preparation.

96146 — *Automated Psychological Testing:*

1. Single standardized instrument administered via automated electronic platform.

2. No provider supervision required during administration.

3. Limited to once per date of service.

4B. TMS — TRANSCRANIAL MAGNETIC STIMULATION (Codes: 90867, 90868, 90869)

4B.1 TMS — Criteria for Members Under 18 (Ages 15–17)

All of the following criteria must be met:

1. *Age:* Member is 15 years of age or older at time of treatment initiation. TMS is not authorized for members under age 15 (no FDA clearance exists; insufficient evidence for routine coverage).

2. *Diagnosis:* Confirmed DSM-5-TR diagnosis of Major Depressive Disorder (MDD), single or recurrent episode (ICD-10: F32.1, F32.2, F32.3, F33.1, F33.2, F33.3).

3. *Severity:* Current depressive episode is moderate to severe, documented by a validated severity scale score (PHQ-A ≥10 in adolescents, CDI-2 score in the clinically significant range, or equivalent validated instrument).

4. *Treatment failure or intolerance:* Documentation of inadequate response to at least one adequate antidepressant medication trial in the current episode (adequate = appropriate dose for age/weight and ≥4 weeks duration), OR documented clinical contraindication or significant adverse effects precluding antidepressant use.

5. *Device clearance:* Treatment is provided using an FDA-cleared TMS device for adolescents (ages 15–21), including: - NeuroStar (FDA clearance: March 2024 for ages 15–21) - MagVenture TMS Therapy (FDA clearance: August 2025 for ages 15–21) - Other devices as cleared for adolescents by FDA prior to date of service

6. *Provider supervision:* Treatment is supervised by a child and adolescent psychiatrist or psychiatrist with documented experience treating adolescent MDD.

7. *Informed consent:* Written informed consent from parent or legal guardian is documented. Patient assent is obtained where developmentally appropriate.

8. *Screening:* Patient has been evaluated for absolute contraindications to TMS prior to initiation, including ferromagnetic implants near the head, implanted stimulators in the cranial region, and active seizure disorder.

9. *Acute course:* Authorization for initial acute course is up to 36 sessions (6 weeks of 5 sessions/week). Extensions require documented clinical response and ongoing medical necessity.

4B.2 TMS Code-Specific Criteria

`90867` — *Initial TMS Treatment Session:*

1. All 4B.1 criteria met.

2. Initial session includes cortical mapping, motor threshold determination, and first treatment delivery.

3. Billed once per course of treatment for the initial setup and delivery session.

`90868` — *Subsequent TMS Delivery Sessions:*

1. All 4B.1 criteria met for the course of treatment.

2. Each subsequent treatment session after the initial.

3. Ongoing documentation of treatment response and tolerability.

`90869` — *Subsequent Motor Threshold Re-Determination:*

1. Clinical justification for re-determination (e.g., significant change in patient condition, hair loss, equipment change, extended gap in treatment).

2. All 4B.1 criteria met for the ongoing course.

4C. ECT — ELECTROCONVULSIVE THERAPY (Code: 90870)

4C.1 ECT — Criteria for Members Under 18 (Ages 13–17)

All of the following criteria must be met:

1. *Age:* Member is 13 years of age or older. ECT is FDA-cleared for patients aged 13 and older for catatonia and treatment-resistant severe MDD. ECT in patients under 13 is considered on a case-by-case basis with extraordinary clinical justification.

2. *Diagnosis:* At least one of the following DSM-5-TR diagnoses: a. Severe MDD (F32.2, F32.3, F33.2, F33.3) with one or more of the following: - Failure of ≥2 adequate antidepressant trials (different pharmacological mechanisms) in current episode - Active psychotic features - Life-threatening severity (active suicidality with plan/intent, inability to maintain nutrition, severe agitation) - Rapid response clinically required - Documented intolerance/contraindication to antidepressants preventing adequate pharmacotherapy trials b. Catatonia (F20.2, F44.2, or catatonic specifier) failing to respond to adequate benzodiazepine treatment (positive lorazepam test with failure to sustain response) OR malignant catatonia with life-threatening autonomic instability c. Severe acute mania (F30.1, F31.1, F31.2) refractory to mood stabilizers and antipsychotics d. Treatment-refractory schizophrenia or schizoaffective disorder (F20, F25) with severe acute exacerbation

3. *Medical clearance:* Pre-ECT medical evaluation completed including anesthesia assessment. No elevated intracranial pressure with mass effect (the only absolute contraindication to ECT).

4. *Consent:* Written informed consent from parent or legal guardian is documented. Patient assent is obtained and documented. Where applicable, compliance with state-specific additional consent or attestation requirements is confirmed (see Section 7 — Texas requirements).

5. *Psychiatrist supervision:* ECT is ordered and supervised by a board-certified psychiatrist or a psychiatrist with documented training and experience in ECT. Child and adolescent psychiatrist consultation is strongly recommended.

6. *Acute course:* Typically 6–12 sessions at 3–5 sessions/week over 2–4 weeks. Extensions beyond 12 sessions require documentation of ongoing response and medical necessity.

7. *Continuation/Maintenance ECT:* Authorized when the patient achieved a meaningful clinical response during acute ECT course and has: a. History of relapse with pharmacotherapy alone b. Inability to tolerate or failed maintenance pharmacotherapy c. Ongoing documented clinical necessity

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4D. INPATIENT BH/SA — FACILITY (Revenue Codes: 0101, 0114, 0116, 0118, 0124, 0126, 0128, 0134, 0136, 0138, 0144, 0146, 0148, 0154, 0156, 0158, 1001)

4D.1 Inpatient Psychiatric Admission Criteria (Under 18)

Intensity of Service Requirements — ALL of the following must be met:

1. The member requires intensive, comprehensive, multimodal psychiatric treatment with 24-hour medical and nursing supervision that cannot be provided in a partial hospitalization, intensive outpatient, or outpatient setting.

2. Active treatment (not custodial, social, or respite care) is required on a daily basis, including a combination of psychiatric evaluation, medication management, nursing/medical intervention, individual and/or group psychotherapy, and multidisciplinary team involvement.

3. Lower levels of care (PHP, IOP, outpatient) have been considered, attempted, or have been clinically determined to be insufficient or unsafe.

4. A child and adolescent psychiatrist, or general psychiatrist in the absence of a CAP, is involved in the admission decision and confirms the admission determination within 24 hours.

5. Discharge planning is initiated on the day of admission.

6. An individualized treatment plan addressing biological, psychological, family, and social needs is completed within 24 hours of admission.

Severity of Illness — ANY ONE of the following must be present:

7. Active suicidal ideation with plan, intent, or means documented within 72 hours of admission in the context of a diagnosable psychiatric condition.

8. Suicide attempt or act of self-harm within 72 hours of admission.

9. Severe self-injurious behavior (cutting, burning, severe head banging) that poses significant, immediate threat to life or limb and cannot be safely managed at a lower level of care.

10. Homicidal ideation with plan, intent, and/or available means.

11. Command auditory hallucinations directing the patient to harm themselves or others.

12. Acute psychotic episode (first-break or relapse) with grossly disorganized behavior, severe paranoia, or inability to maintain safety preventing treatment at lower level.

13. Severe agitation or dangerous aggression toward others that requires 24-hour physical containment.

14. Severe eating disorder with acute medical instability: weight <75% of ideal body weight, severe electrolyte abnormalities, or cardiac compromise requiring medical monitoring concurrent with psychiatric treatment.

15. Acute mania with dangerous behavior (POS 21 or 51).

16. Acute psychiatric decompensation causing inability to maintain adequate nutrition or self-care AND appropriate community supports are unavailable or insufficient.

17. Need for initiation of a psychotropic medication with high adverse-effect risk requiring monitored inpatient setting (e.g., clozapine initiation in an adolescent).

18. Severe adverse effects from psychotropic medications requiring inpatient medical management.

AACAP-Specific Pediatric Admission Requirements:

19. The psychiatric disorder causes significant impairment in at least two areas of the child's life (school performance, peer relationships, family relationships, daily functioning).

20. Proposed treatment is relevant to the documented diagnosis and reasonably expected to benefit the member.

21. For members under age 14: Admission should be to an inpatient unit designed and equipped for children and adolescents, physically separate from adult psychiatric units, unless compelling clinical reasons require otherwise.

22. For members ages 14–17: May be admitted to age-appropriate adolescent programs; co-admission to adult units requires documented clinical justification.

23. CALOCUS-CASII composite score is consistent with Level 6 (Secure 24-Hour Services with Psychiatric Management), where CALOCUS has been performed.

4D.2 Inpatient SUD — ASAM Level 4.0 (Under 18)

All of the following must be met:

1. Active DSM-5-TR substance use disorder diagnosis as primary clinical need.

2. ASAM 6-Dimension Assessment completed by a qualified SUD professional documenting: a. Dimension 1: Acute withdrawal potential requiring medical management (e.g., severe alcohol withdrawal risk, opioid withdrawal with medical complications) b. Dimension 2: Biomedical conditions requiring concurrent medical management c. Dimension 3: Co-occurring emotional/behavioral conditions requiring inpatient-level psychiatric management d. Dimensions 4–6 assessed and documented

3. Treatment cannot be safely managed at ASAM Level 3.7 (residential) or lower.

4. Adolescent-specific SUD treatment programming that is age-appropriate and integrates family involvement is utilized.

5. AACAP and ASAM guidelines for adolescent SUD are followed; MAT for opioid use disorder in adolescents (ages 16+) should be considered and offered per ASAM/AACAP recommendations.

4D.3 Continued Inpatient Stay Criteria (Under 18)

Continued inpatient authorization requires documentation of ALL of the following on each review:

1. Ongoing active psychiatric symptoms that require 24-hour medical supervision and cannot be safely managed at a lower level.

2. Active treatment is occurring daily (not maintenance or waiting for placement).

3. Measurable progress toward treatment goals is documented, or reasons for lack of expected progress are clinically explained.

4. Discharge planning is actively ongoing with identified step-down level of care.

5. Discharge to a lower level of care has not yet become clinically safe.

4E. INPATIENT BH/SA — PROFESSIONAL (Codes: `90785`, `90791`, `90832`, `90834`, `90836`, `90838`, `90846`, `90847`, `90849`, `90853`, `90863`, `90870`, `90876`, `96121`, `96130`, `96131`, `96132`, `96133`, `96136`, `96137`, `96138`, `96139`, `99232`, `G0407`, `G2074`, `H0010`, `H0011`, `H0017`, `H0018`, `H0019`, `H0035`, `H0038`, `H2012`, `H2036`, `S9484`)

Professional services rendered during an authorized inpatient psychiatric or SUD stay are medically necessary when:

1. The member's inpatient admission meets criteria in Section 4D.1 or 4D.2.

2. Each professional service is: a. Clinically appropriate to the member's current inpatient condition b. Rendered by a qualified provider with appropriate licensure for the specific service c. Documented in the inpatient record with date, provider credentials, and clinical rationale

3. Individual psychotherapy codes (`90832`, `90834`, `90836`, `90838`): Session is with the inpatient member directly; session notes document goals, content, and therapeutic modality used.

4. Family therapy codes (`90846`, `90847`): Clinically indicated; family participation is documented; `90846` (without patient) and `90847` (with patient) are not billed on same date for same family unit.

5. Group therapy (`90849`, `90853`): Group is therapeutically appropriate; group notes document the member's participation and clinical relevance.

6. `90785` (interactive complexity): Add-on only; used when significant communication difficulties are present (e.g., disruptive behavior, mandated reporting obligation, or legally responsible third-party involvement for a minor).

7. `S9484` (crisis intervention): Documented acute psychiatric crisis requiring urgent intervention; distinct from ongoing therapy sessions.

8. `H0010`, `H0011` (detoxification): Member requires medically supervised detoxification as part of SUD treatment in a residential setting.

9. 99232 (subsequent hospital inpatient care): Physician/QHP renders evaluation and management service for inpatient member; documents history, examination, and medical decision-making at moderate complexity.

4F. OUTPATIENT BH/SA — FACILITY (Revenue Codes: 0905, 0906, 0912, 0913)

Outpatient BH/SA facility services are medically necessary when:

1. The member has a current DSM-5-TR behavioral health diagnosis (mental health or SUD) as the primary focus of treatment.

2. Services are provided in an appropriately licensed outpatient behavioral health facility.

3. Treatment is medically necessary to treat active psychiatric or SUD symptoms causing functional impairment.

4. Services are not primarily social, educational, vocational, or recreational in nature.

4G. OUTPATIENT BH/SA — PROFESSIONAL (Codes: H0004, H0005, H0012, H0013, H0014, H0015, H0016, H0035, H2015, S9480, 90792)

Outpatient BH/SA professional services are medically necessary when:

1. The member has a current DSM-5-TR BH diagnosis requiring active clinical treatment.

2. Services are rendered by a licensed professional or qualified provider credentialed by CHP for the service type billed.

3. Treatment addresses active psychiatric or SUD symptoms and is expected to produce measurable clinical benefit.

4. Intensive outpatient (H0015, S9480): - Member requires structured intensive outpatient treatment (minimum 3 hours/day, 3 days/week) that exceeds standard weekly outpatient therapy but does not require PHP or inpatient level. - Appropriate DSM-5-TR diagnosis; active symptoms requiring IOP intensity are documented. - Member is not at imminent risk requiring PHP or inpatient level.

4H. PARTIAL HOSPITALIZATION (Code: S0201)

4H.1 Partial Hospitalization — Initial Authorization (Under 18)

Intensity of Service — ALL of the following must be met:

1. Member requires comprehensive, multimodal psychiatric or SUD treatment with clinical supervision that exceeds intensive outpatient programming but does NOT require 24-hour inpatient care.

2. PHP provides a minimum of 20 hours per week of structured active treatment (not including meals, transportation, or non-clinical activities).

3. Member is NOT at imminent risk of harm to self or others requiring 24-hour containment (if imminent risk exists, inpatient is required).

4. Member has an adequate support system (family, guardian, or supervised placement) to provide safety and support during non-PHP hours.

5. Parent/caregiver is willing and able to participate in treatment (pediatric PHP is family-integrated by clinical standard).

6. If PHP occurs during school hours: access to educational services is arranged or documented as addressed.

7. CALOCUS-CASII composite score is consistent with Level IV (Intensive Integrated Services without 24-Hour Monitoring) for psychiatric PHP. ASAM Level 2.5 supports SUD PHP.

Severity — At least ONE of the following must be present:

8. Recent inpatient psychiatric or SUD discharge with ongoing significant symptoms requiring intensive step-down to prevent readmission.

9. Acute onset or significant decompensation of a DSM-5-TR psychiatric disorder severely interfering with the child's or adolescent's functioning in school, social, or family domains, where PHP is necessary to prevent inpatient admission.

10. Moderate psychiatric symptoms requiring daily clinical monitoring and active treatment, where standard outpatient care (IOP or weekly therapy) is clinically insufficient.

11. Suicidal ideation WITHOUT active plan or intent that requires daily clinical monitoring (if hourly observation is required, inpatient level is appropriate).

12. Significant medication initiation or adjustment (e.g., antipsychotic initiation, lithium titration) requiring close daily monitoring but not 24-hour containment.

4H.2 Continued PHP Authorization (Under 18)

Each continued stay authorization requires:

1. Active psychiatric or SUD symptoms remain at a level requiring PHP intensity (20+ hours/week).
2. Active treatment is occurring in all scheduled PHP sessions with documented clinical progress or explained deviation.
3. Discharge to IOP or outpatient has not yet become clinically safe.
4. Parent/caregiver involvement continues to be documented.
5. Educational coordination continues if PHP occurs during school hours.
6. Step-down to lower level of care is planned and progress toward that goal is documented.

SECTION 5: MEDICAL NECESSITY CRITERIA — DOES NOT MEET CRITERIA

SECTION 5[Z]: ABA THERAPY — DOES NOT MEET CRITERIA

The following exclusions apply to all ABA services under codes 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, and 0373T.

5[Z]-A: Diagnostic Exclusions

5[Z]-A.1 ABA services billed for a member who does NOT have a current, documented DSM-5-TR ASD diagnosis (ICD-10: F84.0, F84.5, F84.8, or F84.9) established through a comprehensive evaluation with validated instruments. ABA billed under any other ICD-10 diagnosis does not meet medical necessity criteria under this policy.

5[Z]-A.2 ASD diagnosis based solely on screening instrument results (M-CHAT-R, ASRS, SCQ, STAT, ASQ-SE, RITA-T, or equivalent) without a comprehensive diagnostic evaluation including validated diagnostic instruments (ADOS-2, ADI-R, CARS-2, or equivalent). Screening instruments are not sufficient as the sole diagnostic basis.

5[Z]-A.3 ABA services requested for conditions other than ASD without a concurrent ASD diagnosis, including:

- ADHD as a sole diagnosis, without co-occurring ASD
- Oppositional Defiant Disorder (ODD) as a sole diagnosis, without co-occurring ASD
- Anxiety disorders as a sole diagnosis, without co-occurring ASD
- Intellectual disability (not otherwise specified) without co-occurring ASD diagnosis
- General behavioral or conduct problems without an ASD diagnosis

Note: Members may have multiple co-occurring diagnoses. ABA is covered under this policy only to the extent that services address the ASD diagnosis. Co-occurring conditions (ADHD, anxiety, ID) may also be present alongside ASD without disqualifying coverage.

5[Z]-A.4 Rett syndrome (ICD-10: F84.2) and childhood disintegrative disorder (ICD-10: F84.3) are NOT classified as Autism Spectrum Disorder under DSM-5-TR. ABA services for members with exclusively F84.2 or F84.3 diagnoses do not qualify under this policy.

5[Z]-A.5 ABA services billed in the absence of documented functional impairment. The presence of an ASD diagnosis, absent documented functional impairment in one or more adaptive behavior domains, does not establish medical necessity.

5[Z]-A.6 ABA services for a member who has achieved maximum practicable functional level with full generalization and maintenance of all treatment goals, and where no maintenance need is documented. (Note: Maintenance of current function to prevent deterioration IS a valid medical necessity basis — see Section 4[Z]-J.2.)

5[Z]-A.7 ASD diagnostic evaluation older than 36 months at the time of initial authorization, without completion of the required re-evaluation per Section 4[Z]-A.4.

5[Z]-B: Provider Qualification Exclusions

5[Z]-B.1 ABA services delivered or supervised by providers who are NOT:

- Board Certified Behavior Analyst-Doctoral (BCBA-D)
- Board Certified Behavior Analyst (BCBA)
- Board Certified Assistant Behavior Analyst (BCaBA) — for technician-level codes only, under BCBA supervision
- Registered Behavior Technician (RBT) — for technician-level codes only, under BCBA supervision
- Independently licensed mental health provider credentialed and contracted with CHP as a QHP for ABA services — for QHP-level codes (`97151`, `97155`, `97156`, `97157`, `97158`) only, when permitted by applicable state law

5[Z]-B.2 BCBA supervision ratio falls below the policy minimum: fewer than *10% of the RBT/technician's monthly direct treatment hours* are supervised; or fewer than *2 face-to-face supervision contacts per month*; or supervision does not include direct observation of treatment by the BCBA; or supervision documentation is absent.

5[Z]-B.3 Code `97151` (behavior identification assessment) billed by an RBT, paraprofessional, BCaBA acting independently, or other provider who does not meet QHP standards for behavior identification assessment.

5[Z]-B.4 Code `97155` (protocol modification with patient) billed without documented face-to-face patient presence. Protocol review, staff supervision, or treatment planning conducted without the patient present are not billable under `97155`.

5[Z]-B.5 Codes `0362T` or `0373T` billed for sessions where the QHP is NOT physically on-site and immediately interruptible, or where fewer than two technicians are present, or where the environment has not been customized for safety — any one of these three required elements being absent renders the Category III code inapplicable.

5[Z]-B.6 ABA services delivered in states requiring BCBA licensure (TX, GA, DC, MD, IN, OH) by BCBAs who do not hold current, valid state licensure as required by applicable state law. Florida providers must comply with § 393.17 certification requirements.

5[Z]-B.7 Authorization of hours that exceed the BCBA supervisor's documented supervisory capacity. A BCBA cannot effectively maintain the 10% minimum supervision ratio for all supervised technicians beyond reasonable caseload limits. Requests resulting in a demonstrable supervisory deficit will not be authorized.

5[Z]-C: Service-Type Exclusions

5[Z]-C.1 Custodial care, respite care, or babysitting: ABA services that are primarily supervisory or custodial in nature — characterized by the absence of active skill-building or behavior reduction protocols, trained clinical staff implementing evidence-based strategies, and session-by-session behavioral data collection — do not meet medical necessity.

5[Z]-C.2 Educational services that are the responsibility of the school district under IDEA/IEP: Services that the school system is legally obligated to provide under IDEA through the member's IEP or IFSP are excluded from insurance coverage. Important MHPAEA caveat: This exclusion applies to specific services the school is obligated to provide — not to all ABA provided in a school setting, and not to all ABA for school-age children.

5[Z]-C.3 ABA delivered during school hours when child is enrolled in school-based services: ABA delivered during school hours when the member is enrolled in and receiving school-based ABA services through their IEP does not meet criteria. See Section 4[Z]-H.2.

5[Z]-C.4 Telehealth delivery of codes that require in-person delivery: ABA services billed via telehealth under codes that require in-person delivery (`97153`, `97154`, `0362T`, `0373T`) do not meet criteria. Telehealth delivery of these codes is not an acceptable substitute for in-person services.

5[Z]-C.5 Services duplicative of school-based IEP-funded ABA: ABA services that directly duplicate services already being provided and funded through the member's current IEP. Coordination of care documentation is required to support a non-duplication determination.

5[Z]-C.6 Group therapy (`97154` or `97158`) as the exclusive primary ABA modality without clinical justification: Group treatment codes as the sole ABA modality, without any 1:1 direct treatment component, without documented clinical rationale.

5[Z]-C.7 Vocational training or supported employment without behavioral clinical objectives: Supported employment, job coaching, or vocational training programs billed as ABA without documented specific behavioral targets, data collection, and evidence-based ABA intervention strategies implemented by a BCBA-supervised provider.

5[Z]-C.8 Non-evidence-based ABA derivatives and alternative treatments: The following interventions are not recognized as evidence-based by the NAC National Standards Project, NPDC Evidence-Based Practice list, or other recognized autism intervention research organizations, and are excluded from coverage:

- Facilitated Communication (FC)
- Rapid Prompting Method (RPM) / Spelling to Communicate (S2C)
- Equine therapy / hippotherapy — not evidence-based as an ABA intervention for ASD behavioral targets
- Dolphin-assisted therapy — not evidence-based for ASD behavioral targets
- Music therapy as a standalone intervention — not covered as an ABA service; may be integrated as a component of a BCBA-developed ABA plan with measurable behavioral targets, in which case the ABA-based components may be covered
- Art therapy as a standalone intervention — not covered as an ABA service; may be integrated as a component of a BCBA-developed ABA plan with measurable behavioral targets, in which case the ABA-based components may be covered
- Sensory integration therapy without functional behavioral target — sensory integration therapy billed as ABA without documented, measurable behavioral targets and ABA methodology does not meet criteria; OT-delivered sensory integration is covered under OT benefits when clinically indicated

- Floortime/DIR as a standalone intervention — Floortime/Developmental, Individual Difference, Relationship-based (DIR) model as a standalone replacement for ABA is not covered; DIR components integrated within a BCBA-developed ABA plan with measurable behavioral targets may be covered as part of the ABA program
- Auditory Integration Training (AIT) — not established as evidence-based for ASD behavioral targets
- Holding therapy — contraindicated; classified as not established or harmful
- Chelation therapy — not evidence-based for ASD; associated with potential harm
- Nutritional supplements or special diets billed as ABA services — dietary interventions are not ABA and are not covered under ABA CPT codes
- Educational tutoring (remediation of academic content rather than functional skill acquisition) — academic subject tutoring billed as ABA does not meet criteria; ABA-based instruction targeting functional communication, adaptive skills, or behavioral prerequisites to learning is distinct and may be covered
- Home modifications and assistive devices billed as ABA — physical modifications to the home environment or purchase of assistive devices are not billable as ABA services
- Test preparation / SAT or ACT preparation — not a behavioral health service
- Driving lessons / driver's education — not ABA; not covered under this policy
- Religious instruction — not ABA; not covered under this policy
- Secretin therapy — not evidence-based for ASD
- Other interventions classified as "experimental," "investigational," or "not established" by recognized autism intervention research bodies

5[Z]-C.9 Non-billable time billed under ABA codes:

- Travel time to and from patient home, community, or clinic
- No-show or cancellation fees
- Administrative time (billing, scheduling, non-clinical quality assurance)
- Staff training or BCBA supervision not involving direct patient care
- Report writing billed separately under `97153` or `97155` (report writing is bundled into `97151`)
- Group supervision time not involving the specific patient's services

5[Z]-C.10 `97151` *for routine daily or weekly treatment adjustments:* Code `97151` is for formal initial behavior identification assessment and periodic comprehensive reassessment — not for routine session-to-session treatment planning, daily data review, or weekly program adjustments. Routine clinical management is bundled into the treatment codes (`97153`, `97155`).

5[Z]-C.11 Concurrent billing of `97154` *and* `97158` *for the same session:* Both technician-led group and QHP-led group codes cannot be billed for the same patient group in the same session.

5[Z]-C.12 Concurrent billing of `0373T` *and* `97155` *for the same session:* QHP indirect services and observation are bundled into `0373T`; `97155` cannot be billed concurrently with `0373T`.

5[Z]-C.13 Failure to meet caregiver participation threshold after documented support and accommodation: Where, after good-faith effort and documented accommodation, the caregiver

participation threshold (≥80% of scheduled sessions) continues not to be met without clinically acceptable justification, the caregiver training component of the authorization is subject to reduction. See Section 4[Z]-G.3.

5[Z]-C.14 Lack of measurable progress over 6 months after appropriate plan revisions: Where individualized review (per Section 4[Z]-I.2) confirms that continued ABA does not meet medical necessity due to absence of measurable progress and no clinically supported maintenance need, continued authorization of the same intensity and scope does not meet criteria. A step-down or plan-of-care conference is required.

5[Z]-C.15 Authorization of hours beyond the age-based caps without exceptional clinical justification: Requests for weekly hours exceeding the limits in Section 4[Z]-B1 without documented extraordinary clinical justification and heightened clinical review do not meet standard criteria.

5[Z]–D: Documentation Exclusions

5[Z]-D.1 No BCBA-authored, individualized Behavior Intervention Plan or ABA Treatment Plan is present at the time of the authorization request for treatment codes.

5[Z]-D.2 Treatment goals stated in vague, non-behavioral, or non-measurable terms (e.g., "improve communication," "reduce aggression," "learn to share" without specific, quantifiable behavioral definitions, measurement methods, and mastery criteria).

5[Z]-D.3 No objective behavioral baseline data is provided.

5[Z]-D.4 Reauthorization request submitted without the required Vineland-3 and criterion-referenced assessment (VB-MAPP, ABLLS-R, or AFLS) results per Section 4[Z]-I.3.

5[Z]-D.5 Reauthorization request submitted without objective behavioral data demonstrating the member's response to treatment for the prior authorization period.

5[Z]-D.6 Treatment plan that is clearly a template or generic document not individualized to the member's specific behavioral profile, goals, and clinical presentation.

5[Z]-D.7 Caregiver participation documentation is absent at reauthorization, where caregiver training is included in the treatment plan and no clinical rationale for non-participation is provided.

5[Z]-D.8 Missing or expired physician prescription/referral where required (FL: § 627.6686; OH: § 3923.84; and CHP standard practice).

5[Z]-D.9 Authorization period has lapsed without timely reauthorization submission. Services rendered without current prior authorization are not eligible for retroactive authorization under standard CHP policy unless CHP has separately authorized a retroactive exception.

5[Z]-D.10 Daily session notes that do not include all required elements per Section 5[Z]-G.

5[Z]-E: MHPAEA Compliance — Limitations That Are NOT Applied

In accordance with MHPAEA and CHP's commitment to mental health parity, *the following types of limitations are NOT applied to ABA benefits for fully insured plans subject to MHPAEA:*

5[Z]-E.1 Hard age cutoffs: Categorical exclusions of ABA coverage at specific ages without documentation that comparable age limits apply to medical/surgical benefits under the same plan.

5[Z]-E.2 Annual or lifetime dollar caps: Annual or lifetime dollar limits on ABA benefits that are more restrictive than those applied to comparable medical/surgical benefits. Where state mandates impose dollar caps, CHP evaluates MHPAEA compliance before applying these caps to fully insured plans.

5[Z]-E.3 Hard weekly or annual hour caps without clinical individualization: Categorical weekly or annual hour limits on ABA without individualized medical necessity review. Hour limits applied as part of individualized prior authorization review are permissible.

5[Z]-E.4 Fail-first or step-therapy requirements: Requiring trial of less-intensive ABA as a prerequisite to authorizing medically necessary comprehensive or individual ABA, without a clinical basis for the step requirement.

5[Z]-E.5 Categorical location exclusions: Categorical exclusion of school-based, home-based, or community-based ABA coverage solely on the basis of the setting, without specific analysis of whether the school is obligated to provide the services under IDEA/IEP.

5[Z]-E.6 Mandatory caregiver participation as an absolute condition of authorization without individualized review: Terminating the member's entire ABA authorization solely based on caregiver non-participation without individualized assessment of the clinical impact and without exploring accommodation.

5[Z]-E.7 Progress requirements for continuation inconsistent with medical/surgical standards: Denying continuation of ABA solely for lack of measurable improvement without consideration of whether the condition would clinically deteriorate without treatment, or whether maintenance of current function is medically necessary.

5[Z]-F: ABA Concurrent Service Rules

5[Z]-F.1 Speech-Language Pathology (SLP): Covered concurrently with ABA when addressing distinct, non-overlapping goals. Coordination of care documentation demonstrating complementary (not duplicative) goals is required quarterly per Section 4[Z]-L.3.

5[Z]-F.2 Occupational Therapy (OT): Covered concurrently with ABA when addressing distinct goals. Distinct goals and quarterly coordination of care documentation required.

5[Z]-F.3 Physical Therapy (PT): Covered concurrently with ABA when addressing distinct functional goals. Non-duplication documentation required.

5[Z]-F.4 ABA in multiple settings (clinic + home + community): Coverage is available when services in each setting address distinct goals appropriate to that environment. CHP does not categorically exclude multi-setting ABA.

5[Z]-F.5 Concurrent school-based ABA (IEP-funded) and insurance-funded ABA: Insurance-funded ABA may be covered concurrently with school-based ABA when IEP-funded services are documented and insurance-funded ABA addresses non-duplicative goals. The member's IEP must be provided with initial authorization requests and updated at reauthorization.

5[Z]-F.6 Cannot bill `97153` and `97155` for overlapping time blocks (same minutes), except as described in Section 3A-2 concurrent billing rules.

5[Z]-F.7 Cannot bill `97154` and `97158` in the same session for the same patient group.

5[Z]-F.8 Cannot bill `0373T` and `97155` in the same session.

5[Z]-F.9 Simultaneous billing during overlapping time for concurrent ABA and SLP/OT/PT is not permitted. If a member receives ABA and SLP in overlapping time, only one service may be billed for that time period.

5[Z]-G: ABA Documentation Standards

Daily Session Notes Requirements: Every ABA session (`97153`, `97154`, `97155`, `97156`, `97157`, `97158`, `0362T`, `0373T`) must include a session note containing ALL of the following elements:

1. *Date, start time, stop time, and total session duration*
2. *Setting* (home, clinic/center, community, school)
3. *Provider name, credentials, and BACB certification number*
4. *Goals targeted in that session* (listed by name or code as documented in the BIP)
5. *Data collected on each goal targeted* (trial-by-trial data, event records, interval data, or other objective behavioral measure appropriate to the goal type)
6. *Caregiver involvement* (if applicable): whether caregiver was present, activities conducted with caregiver, caregiver participation in session
7. *Behavior incidents* (if any): documented using Antecedent-Behavior-Consequence (ABC) format, including description of the behavior, antecedent conditions, consequence/response, and any safety measures implemented
8. *Plan modifications or clinical notes:* Any changes to the protocol, reinforcer adjustments, prompt level changes, or other clinical decisions made during or after the session

Treatment Plan Update Requirements: At each 6-month reauthorization, the updated treatment plan must include ALL of the following:

1. *Progress on each goal with quantitative data* — numerical comparison of current performance to baseline and prior period
2. *New goals added* and *goals discontinued*, with rationale for each
3. *Hour utilization versus authorized hours* for the prior period, including an explanation if there is significant under-utilization
4. *Caregiver training completion* — number of sessions scheduled vs. attended; caregiver competency data

5. *Updated Vineland-3 and criterion-referenced assessment results* (VB-MAPP, ABLLS-R, or AFLS)

6. *Plan for transition and discharge* with updated projected timeline and discharge criteria

5A. BH EVALUATIONS — DOES NOT MEET CRITERIA

1. `90792` is billed by a non-physician provider (LCSW, psychologist, LMFT, LPC — these providers must use `90791`).

2. `90791` and `90792` are billed by the same provider on the same date of service.

3. A psychiatric diagnostic evaluation is billed for a routine therapy session or medication management check.

4. Diagnostic evaluation is conducted solely for administrative, legal, vocational, educational placement, or forensic purposes without concurrent clinical treatment need.

5. A repeat diagnostic evaluation is billed within 12 months without documented medical necessity justification for re-evaluation.

6. `96130` and `96132` are billed in the same testing episode (mutually exclusive within a single episode).

7. Evaluation/interpretation codes (`96130`–`96133`) are billed without corresponding test administration codes (`96136`/`96137`, `96138`/`96139`, or `96146`).

8. Technician bills evaluation or interpretation codes (`96130`–`96133` are QHP-only).

9. Testing is performed using instruments that are not standardized with national normative data.

10. Testing is performed more than once per calendar year per testing type without documented medical necessity.

11. Testing is performed primarily for educational placement decisions or legal proceedings without concurrent clinical treatment need.

12. Testing is used for routine progress monitoring during ongoing therapy (brief screening codes apply for routine monitoring).

5B. TMS — DOES NOT MEET CRITERIA

1. Member is under 15 years of age (no FDA clearance for TMS; insufficient evidence for routine coverage in this age group).

2. Primary diagnosis is not Major Depressive Disorder (MDD) — bipolar depression, PTSD, schizophrenia, and anxiety disorders are not FDA-cleared indications for TMS and lack sufficient evidence for routine coverage in adolescents.

3. Current depressive episode severity is mild (PHQ-A <10 or equivalent) without documented significant functional impairment.

4. No documented failure of or intolerance to at least one adequate antidepressant medication trial.

5. Ferromagnetic implants in or near the head are present (absolute contraindication).

6. Active seizure disorder or history of seizures other than isolated febrile seizures in infancy (absolute contraindication for adolescent TMS).

7. Active psychotic symptoms without adequate treatment — TMS is not appropriate for active psychosis; ECT should be considered.

8. TMS device used does not have FDA clearance for the adolescent age group (15–21) as of the date of service.

9. Depression is entirely attributable to active substance use without concurrent SUD treatment.

10. Requested for continuation/maintenance TMS without documented acute TMS response during prior course.

5C. ECT — DOES NOT MEET CRITERIA

1. Member is under 13 years of age without extraordinary documented clinical justification approved by a senior psychiatrist.

2. Elevated intracranial pressure with mass effect is present (absolute contraindication to ECT).

3. Primary diagnosis is mild-to-moderate depression that has not failed at least two adequate antidepressant trials with different mechanisms.

4. Primary SUD without co-occurring psychiatric condition meeting ECT criteria.

5. Chronic pain as sole indication (not a recognized ECT indication).

6. Cognitive deficits as sole indication (not a recognized ECT indication).

7. Patient lacks capacity to consent and no appropriate parent, legal guardian, or court-authorized surrogate is available.

8. Addictive disorder (methamphetamine dependence, alcohol use disorder, etc.) without co-occurring psychiatric diagnosis meeting ECT criteria.

Note: The following are relative contraindications requiring anesthesia or medical specialist clearance, not automatic denials: recent myocardial infarction, intracranial lesion without mass effect, pheochromocytoma, cardiac arrhythmias, high anesthesia risk. These require specialist clearance but do not constitute automatic denial of ECT when psychiatric indication is otherwise met.

5D. INPATIENT BH/SA — DOES NOT MEET CRITERIA

1. Member's psychiatric or SUD symptoms are stable and manageable at PHP, IOP, or outpatient level of care.

2. Primary clinical problem is a general medical condition without concurrent active major psychiatric episode requiring inpatient psychiatric treatment.

3. Admission is for custodial, social, respite, or placement purposes rather than active psychiatric treatment.

4. Court-ordered admission that does not independently meet medical necessity criteria (legal order does not override clinical necessity determination).

5. Chronic psychiatric disability without acute exacerbation meeting inpatient intensity criteria.

6. Suicidal ideation without plan, intent, or means in the context of chronic passive ideation without documented acute escalation from baseline.

7. Conduct disorder or oppositional defiant disorder as primary diagnosis without co-occurring psychiatric disorder that independently meets inpatient criteria.

8. Family or social stressors (e.g., parental conflict, school problems, housing instability) without concurrent acute psychiatric decompensation meeting intensity criteria.

9. *Continued stay not medically necessary when:* a. Patient no longer demonstrates imminent risk to self or others b. Patient is no longer grossly impaired, disorganized, or acutely psychotic c. Patient can be safely managed at PHP or IOP level d. Inpatient treatment goals have been met e. Patient is persistently refusing or unable to participate in active treatment without new clinical indications

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5E. OUTPATIENT BH/SA — DOES NOT MEET CRITERIA

1. No current DSM-5-TR behavioral health diagnosis as the primary focus of service.

2. Services are rendered primarily for social, educational, vocational, or recreational purposes without a diagnosable clinical BH condition.

3. Treatment modality is experimental, investigational, or lacks peer-reviewed efficacy evidence (e.g., treatments not endorsed by AACAP, APA, or equivalent specialty bodies).

4. Services are rendered by an unlicensed provider not under appropriate licensed supervision.

5. Duplicate billing for the same service on the same date by the same provider.

6. Sessions are primarily for life coaching, personal development, parenting skills, or generic stress management without a diagnosable BH condition.

7. IOP (`H0015`, `S9480`): Member's symptoms are stable and manageable with standard weekly outpatient therapy without the structured intensity of IOP.

8. IOP: Member requires a higher level of care (PHP or inpatient) than IOP can safely provide.

5F. PARTIAL HOSPITALIZATION — DOES NOT MEET CRITERIA

1. Member requires 24-hour observation, containment, or nursing-level monitoring → inpatient level is required.

2. Member's symptoms are stable and manageable with IOP or standard outpatient treatment.

3. PHP program does not provide a minimum of 20 hours/week of active treatment.

4. Multiple absences from scheduled PHP programming without documented clinical justification.

5. Care is primarily social, custodial, recreational, or respite-based.

6. PHP is used for chronic management of a stable psychiatric condition without evidence of acute decompensation.

7. Member is cognitively or clinically unable to participate in active treatment and alternative step-down is clinically appropriate.

8. Member presents with significant elopement risk, unmanageable physical aggression, or acute psychosis requiring 24-hour management — PHP milieu is clinically unsafe.

SECTION 6: CLINICAL BACKGROUND

6A. ABA Therapy

Applied Behavior Analysis (ABA) is a scientific discipline based on the principles of learning theory and behavior analysis. ABA therapy for ASD is recognized as an evidence-based, medically necessary treatment by the American Academy of Pediatrics (AAP), AACAP, the U.S. Surgeon General, and numerous specialty bodies. ABA is effective across the lifespan but evidence is strongest for early intervention in young children (ages 2–8), where intensive comprehensive ABA (30–40 hours/week) has been shown in multiple randomized controlled trials and meta-analyses to produce significant improvements in IQ, language, adaptive behavior, and social skills.

ABA for ASD encompasses a range of evidence-based intervention models, including:

- *Discrete Trial Training (DTT):* Structured, massed-trial teaching in controlled settings
- *Natural Environment Teaching (NET):* Skill teaching embedded in natural routines and activities
- *Pivotal Response Training (PRT):* Targeting "pivotal" skills (motivation, self-management, responsiveness to cues) that produce broad improvements
- *Functional Communication Training (FCT):* Teaching communicative replacements for challenging behaviors
- *Early Start Denver Model (ESDM):* Developmental-behavioral approach combining ABA and developmental frameworks for young children
- *Verbal Behavior Approach:* ABA targeting language as verbal operants (mands, tacts, intraverbals, echoics)
- *Social Skills Training:* Group or individual instruction in social interaction skills using behavioral principles

Evidence Base: The BACB Ethics Code for Behavior Analysts (2022) and the CASP ABA Practice Guidelines Version 3.0 (May 2024) serve as the primary clinical authorities governing ABA service delivery standards under this policy. The NASEM 2025 report concluded that ABA meets the standard of "reliable evidence of efficacy" across the lifespan, supporting treatment for children, adolescents, and adults with ASD.

6B. BH Evaluations

Psychiatric diagnostic evaluations and psychological/neuropsychological testing are medically necessary when a clinician requires objective, standardized data to establish or clarify diagnosis, assess cognitive and functional status, guide treatment planning, or evaluate treatment response. The AACAP Practice Parameters for Psychiatric Assessment of Children and Adolescents establish comprehensive standards for pediatric psychiatric evaluation, including the requirement to evaluate the child in the context of family, school, and community, and to obtain informant reports from parents, teachers, and other relevant adults.

6C. TMS

Transcranial magnetic stimulation (TMS) delivers repetitive magnetic pulses to targeted cortical regions to modulate neuronal activity. TMS was first FDA-cleared for adult MDD in 2008. In 2024 and 2025, FDA clearances were extended to adolescents aged 15–21 (NeuroStar, March 2024; MagVenture, August 2025). Clinical data on TMS in adolescents demonstrates meaningful improvement in depression symptoms with a favorable safety profile.

6D. ECT

ECT is among the most effective treatments for severe, treatment-resistant depression, acute mania, and malignant catatonia, with response rates of 70–90% across indication categories. ECT was reclassified from FDA Class III to Class II for catatonia and severe MDD requiring rapid response in patients aged 13 and older in 2018. The APA and AACAP both support the use of ECT in adolescents for the same indications as adults when pharmacotherapy has failed or is contraindicated.

6E. Inpatient Psychiatric Care (Pediatric)

AACAP's Practice Parameters on Inpatient Hospital Treatment of Children and Adolescents establish that psychiatric hospitalization is medically necessary when: (1) the disorder is of sufficient severity to cause significant impairment in ≥2 life areas, (2) treatment is relevant and likely to benefit the patient, and (3) other available less-restrictive resources have been considered and are not appropriate. The CALOCUS-CASII provides a validated, AACAP-endorsed framework for level-of-care placement decisions for children ages 6–17.

6F. PHP and Outpatient BH

Partial hospitalization provides intensive structured psychiatric treatment (minimum 20 hours/week) as an alternative to or step-down from inpatient hospitalization. CMS LCD L33626 defines the clinical standards for psychiatric PHP programs. The CALOCUS-CASII Level IV criteria support PHP-level placement for pediatric patients with acute psychiatric symptoms who can maintain safety outside of a 24-hour supervised setting.

SECTION 7: STATE AND FEDERAL REGULATORY CONSIDERATIONS

7A. Federal Requirements (All States)

MHPAEA (Mental Health Parity and Addiction Equity Act):

- Authority: 29 U.S.C. § 1185a; 26 U.S.C. § 9812; 42 U.S.C. § 300gg-26
- PA requirements, medical necessity criteria, and benefit limitations for BH/SUD services shall not be more restrictive than those applied to analogous medical/surgical benefits within the same classification.
- Annual dollar caps, visit limits, and age limits applicable to ABA and other BH services are subject to MHPAEA parity analysis. State-mandated dollar caps or age restrictions that are more restrictive than limitations on comparable medical/surgical benefits are unenforceable under MHPAEA for plans subject to the Act.
- The 2013 MHPAEA implementing regulations remain fully in force. The 2024 MHPAEA Final Rule is under non-enforcement review pending litigation as of April 2026.
- *Applies to:* Group health plans with 51+ employees (fully insured and self-funded); individual market plans under ACA.

ACA Essential Health Benefits:

- Behavioral health treatment, including mental health and SUD services, is one of ten ACA-required essential health benefits for fully insured individual and small group plans.
- EHB mandates apply to Level Funded and Fully Insured products; ASO (self-funded) ERISA plans are not subject to EHB requirements.

ASO Plan Note: State insurance mandates (including autism/ABA mandates) generally do NOT apply to self-funded ERISA plans unless the plan voluntarily adopts them. MHPAEA applies to self-funded ERISA plans with 51+ employees.

State Mandate Applicability — ABA and BH: The state mandate provisions below apply ONLY to fully insured plans subject to state insurance regulation. For ASO/self-funded ERISA plans, state mandates do not apply; the hour caps, supervision requirements, and clinical criteria set forth in this policy (including Sections 4[Z]-B1, 4[Z]-C, 4[Z]-E, and 4[Z]-G) govern medical necessity review in lieu of state mandates.

7B. Texas (TX)

ABA/Autism Mandate — Texas Insurance Code § 1355.015 (SB 1484, effective September 1, 2013):

Provision	Statutory Requirement
Applicable Plans	All fully insured health benefit plans delivered in Texas; group and individual market
Age Limits	No maximum age cap; however, individual must have been *diagnosed with ASD before age 10* to be eligible for mandate coverage
Annual Dollar Cap	No cap for insured individuals diagnosed before age 10 who are under age 10; *$36,000/year* for covered individuals age 10 and older (diagnosed before age 10)
Weekly/Visit Limits	None specified in statute

Provision	Statutory Requirement
Diagnosis-by-Age Requirement	ASD diagnosis must have been established *before the individual's 10th birthday*
Provider Requirements	ABA services must be delivered by a BCBA or under BCBA supervision; Texas BCBA state licensure through Texas Department of Licensing and Regulation (TDLR) required
Physician Requirement	CHP standard: physician prescription recommended; state mandate does not specify independently
ASO Plans	Mandate does NOT apply; criteria of this policy apply

MHPAEA Parity Analysis (Fully Insured Plans): The $36,000/year annual dollar cap for members age 10+ and the diagnosis-before-age-10 eligibility requirement are potential Quantitative Treatment Limitations (QTLs) and Non-Quantitative Treatment Limitations (NQTLs) under MHPAEA. *Curative Health Plan will evaluate MHPAEA compliance before applying the Texas $36,000 cap or diagnosis-by-age-10 requirement to fully insured plan members.* Members subject to MHPAEA-covered plans may receive coverage beyond the Texas statutory floor.

BH/Mental Health Parity: PA requirements for BH/SUD services under fully insured and level-funded plans in Texas must comply with MHPAEA. PA decisions must be made by Texas-licensed physicians (HB 3812, 2025); same-specialty reviewer required for appeals. PA Gold Card exemption applies when a provider achieves ≥90% approval rate over a 12-month evaluation period.

ECT Additional Requirements (Texas): Texas requires additional physician attestation for ECT in adolescents under specific circumstances. Compliance with Texas Health & Safety Code ECT provisions is required for fully insured and level-funded products. For pediatric ECT: Confirm that the treating facility has the requisite certifications and the treating psychiatrist has complied with Texas-specific consent and documentation requirements.

7C. Florida (FL)

ABA/Autism Mandate — Florida Statutes § 627.6686 (group health insurance); § 641.31098 (group HMOs) — "The Steven A. Geller Autism Coverage Act" (SB 2654, enacted 2008; amended 2016):

Provision	Statutory Requirement
Applicable Plans	Group health insurance plans only; Florida state group insurance program (§ 110.123) included; does NOT apply to individual market plans or small group plans (as originally enacted)
Age Limits	Individuals *under age 18* OR age 18+ if *still enrolled in high school*
Annual Dollar Cap	*$36,000/year* (inflation-adjusted annually per CPI-Medical)
Lifetime Dollar Cap	*$200,000 lifetime*

Provision	Statutory Requirement
Diagnosis-by-Age Requirement	Individual must have been diagnosed with a developmental disability *at age 8 or younger*
Provider Requirements	ABA services must be provided by an individual certified pursuant to Florida Statutes § 393.17 OR licensed under Chapter 490 (psychologist) or Chapter 491 (clinical social worker, LMFT, LPC)
BCBA Licensure	Florida does not have a separate state BCBA licensure law; § 393.17 certification is the Florida-specific credential pathway
Physician Requirement	Coverage is limited to treatment prescribed by the insured's treating physician (*physician prescription is required under this mandate*)
Habilitative Services	Coverage cannot be denied on the basis that provided services are habilitative in nature
ASO Plans	Mandate does NOT apply; criteria of this policy apply

MHPAEA Parity Analysis (Fully Insured Plans): The $36,000/year annual cap, the $200,000 lifetime cap, and the diagnosis-before-age-8 eligibility requirement are potential QTL and NQTL violations under MHPAEA. *Curative Health Plan will evaluate MHPAEA compliance before applying Florida statutory caps and age/diagnosis requirements to MHPAEA-covered fully insured plans.* The prohibition on denial of habilitative services is consistent with MHPAEA principles and is applied to all applicable plans.

BH/Mental Health Parity: Florida fully insured plans are subject to MHPAEA for all BH/SUD benefits. ACA EHB requirements apply to non-grandfathered individual and small group plans in Florida.

7D. Georgia (GA)

ABA/Autism Mandate — Georgia Code § 33-24-59.10 — "Ava's Law" (enacted 2015; amended by SB 118; further amendments December 2019):

Provision	Statutory Requirement
Applicable Plans	State-regulated private insurance group policies; health benefit plans for state employees
Age Limits	Coverage required for individuals *age 20 or under* (under age 21)
Annual Dollar Cap	*$35,000/year* for applied behavior analysis specifically
Weekly/Visit Limits	None — statute explicitly prohibits limits on number of visits (§ 33-24-59.10(b)(3))
Diagnosis Requirement	Licensed physician or licensed psychologist must demonstrate ongoing medical necessity *at least annually*

Provision	Statutory Requirement
Provider Requirements	ABA must be provided by a person professionally certified by a national board of behavior analysts (BCBA) OR performed under the supervision of a BCBA; Georgia BCBA state licensure through the Georgia Behavior Analyst Licensing Board (GBALB) required (enacted 2022)
Services Covered	ABA; counseling services by licensed psychiatrist, psychologist, counselor, or social worker; SLP, OT, PT, and marriage/family therapy
IDEA Non-Duplication	Does not require coverage where services are the responsibility of the school under IDEA/IEP
ASO Plans	Mandate does NOT apply; criteria of this policy apply

MHPAEA Parity Analysis (Fully Insured Plans): The $35,000/year annual cap and the under-age-21 upper age limit are potential QTL violations under MHPAEA. *Curative Health Plan will evaluate MHPAEA compliance before applying the Georgia $35,000 annual cap and age-21 limit to MHPAEA-covered fully insured plans.*

BH/Mental Health Parity: Georgia fully insured plans must comply with MHPAEA for all BH/SUD benefits. Ava's Law's prohibition on visit limits for ABA is consistent with MHPAEA parity requirements.

7E. Washington, DC (DC)

ABA/Autism Mandate — DC Code § 31-3271 et seq. (Council Bill B20-0302, enacted 2013; effective January 1, 2014); ACA Essential Health Benefit requirements apply to all non-grandfathered plans sold through the DC Health Benefit Exchange:

Provision	Statutory Requirement
Applicable Plans	Individual and small group non-grandfathered plans sold through the DC Health Benefit Exchange; ACA EHB requirements apply to non-grandfathered plans in the individual and small group markets
Age Limits	*None* — no age restrictions on ABA coverage
Dollar Caps	*None* — no annual or lifetime dollar limits
Weekly/Visit Limits	None
Services Covered	Habilitative services for the treatment of ASD, including ABA; ABA cannot be classified as "educational" to deny benefits
Provider Requirements	No specific provider requirements stated in DC statute; DC BCBA state licensure through the DC Board of Psychology required (enacted 2024)
Grandfathered Plans	Mandate does NOT apply to grandfathered plans (issued prior to March 23, 2010)
ASO Plans	Mandate does NOT apply; federal MHPAEA applies; criteria of this policy apply

MHPAEA Parity Analysis: The DC mandate, with no age limits and no dollar caps, is the most MHPAEA-consistent of all CHP operating states. No parity conflict exists between the DC mandate and MHPAEA requirements. For CHP fully insured plans in DC, ABA should be authorized based solely on medical necessity without age or dollar limitations (for non-grandfathered plans). The prohibition on reclassifying ABA as "educational" to deny benefits is consistent with MHPAEA principles and is applied to all applicable CHP plan types.

BH/Mental Health Parity: DC ACA-compliant plans must provide mental health benefits at parity with medical/surgical benefits. DC's broad mandate and MHPAEA alignment make DC the least restrictive operating state for CHP ABA coverage.

7F. Maryland (MD)

ABA/Autism Mandate — Maryland Insurance Code § 15-835 (Maryland Autism Insurance Reform Act; strengthened by SB 946 in 2019; Habilitative Services Mandate):

Provision	Statutory Requirement
Applicable Plans	All insurers, health benefit plans, nonprofit health service plans, and health maintenance organizations in Maryland; individual plans, fully insured large group plans, and fully insured small group plans — broadest applicability of all CHP operating states
Age Limits	*None* — no upper age restriction on ABA coverage mandate
Dollar Caps	*None* — regulations establish minimum floors, not ceilings
Minimum Hour Floors (Not Ceilings)	Ages 18 months through 5 years: *25 hours/week minimum* (insurer cannot deny coverage below this floor); Ages 6 through 18 years: *10 hours/week minimum* (insurer cannot deny coverage below this floor); No statutory minimum for adults 19+
Experimental/Investigational Denial Prohibition	Explicit statutory prohibition on denying ABA on grounds that it is "experimental," "investigational," or not medically proven
Educational Reclassification Prohibition	ABA cannot be reclassified as an "educational service" to deny insurance coverage
Services Covered	ABA as a habilitative service; must be covered regardless of whether the condition is expected to improve
Provider Requirements	BCBA or supervised provider; Maryland state BCBA licensure through the Maryland State Board of Professional Counselors and Therapists required (enacted 2014)
Periodic Review	Plans may require review typically every 6 months (consistent with CHP standard authorization periods)
ASO Plans	Mandate does NOT apply; federal MHPAEA applies; criteria of this policy apply

MHPAEA Parity Analysis: Maryland's mandate is the most expansive and most parity-consistent of all CHP operating states. No MHPAEA conflict exists — the Maryland mandate already

exceeds federal parity requirements. For CHP fully insured plans in Maryland: (a) ABA must be covered for members of all ages; (b) no dollar caps apply; (c) for children 18 months–5 years, a minimum of 25 hours/week must be authorized if clinically supported — this is a floor, not a ceiling; (d) experimental or educational denial rationales are prohibited.

Caregiver/Provider Note: For Maryland members aged 18 months through 5 years, CHP shall not deny below the 25 hours/week minimum floor when clinical assessment by the supervising BCBA supports this intensity. CHP may still conduct individualized medical necessity review above the floor.

BH/Mental Health Parity: Maryland's parity requirements for BH/SUD benefits align with and in some respects exceed MHPAEA. Maryland Insurance Administration oversight applies to all fully insured plans.

7G. Indiana (IN)

ABA/Autism Mandate — Indiana Code § 27-8-14.2 (Indiana was the first state in the United States to mandate ABA coverage, enacted 2001):

Provision	Statutory Requirement (Commercial Plans)
Applicable Plans	Group health and accident insurance policies (mandated coverage); individual plans: required to offer (not mandate) ASD coverage; ASO/ERISA self-funded plans exempt
Age Limits (Commercial)	*None* — Indiana commercial mandate has no upper age restriction
Dollar Caps (Commercial)	*None* — no annual or lifetime dollar caps for commercial plans
Weekly Hour Limits (Commercial)	None
Provider Requirements	BCBA certification; Indiana state BCBA licensure through Indiana Professional Licensing Agency (IPLA) required (enacted 2021)
Physician Requirement	Care plan approved by treating physician required for commercial plans
Accreditation (Medicaid only)	Indiana Medicaid mandates CASP/ACQ or BHCOE accreditation for Medicaid ABA providers by October 2027 (does not apply to CHP commercial)
ASO Plans	Mandate does NOT apply; criteria of this policy apply

IMPORTANT — Indiana Medicaid Changes (Effective April 1, 2026) — MEDICAID ONLY, NOT COMMERCIAL:

The following changes apply *exclusively to Indiana Medicaid (IHCP) ABA benefits* and do *NOT apply* to Curative Health Plan commercial products:

Indiana Medicaid Change (April 1, 2026)	CHP Commercial Impact
6% ABA provider rate cut (April 2026); additional 4% (April 2027)	Not applicable to CHP commercial

Indiana Medicaid Change (April 1, 2026)	CHP Commercial Impact
4,000-hour lifetime cap on "Comprehensive ABA" (defined by Indiana Medicaid as ≥16 hours/week)	*Does NOT apply to CHP commercial plans*
"Targeted ABA" (<16 hours/week per Indiana Medicaid definition) exempt from lifetime cap	CHP commercial does not impose this distinction
1:8 BCBA:RBT supervision ratio requirement	CHP commercial applies the 10% supervision ratio set in Section 4[Z]-E
16–18 hours caregiver coaching required per 6-month authorization period	CHP requires 1–4 hrs/month minimum per Section 4[Z]-G; ≥80% attendance threshold
In-person only for `97151`–`97154` and `0373T`	CHP commercial telehealth policy applies per Section 3A-1
Adults age 21+: No new ABA authorizations under EPSDT (effective October 2026)	CHP commercial covers members of all ages based on medical necessity

> Indiana Medicaid definitions of "Comprehensive ABA" (≥16 hours/week) and "Targeted ABA" (<16 hours/week) differ from the CASP/BACB definitions (Comprehensive: ≥26 hours/week; Focused: 10–25 hours/week) used in this policy. CHP commercial plan uses the CASP/BACB definitions.

MHPAEA Parity Analysis (Commercial Plans): Indiana commercial mandate has no age caps and no dollar caps — no MHPAEA parity conflict for fully insured commercial plans. The Indiana Medicaid 4,000-hour lifetime cap would constitute a QTL violation under MHPAEA if applied to commercial plans; CHP commercial plans do not apply this limit.

BH/Mental Health Parity: Indiana fully insured group plans are subject to MHPAEA. Indiana's commercial ABA mandate, with no age limits and no dollar caps, is fully consistent with MHPAEA requirements.

7H. Ohio (OH)

ABA/Autism Mandate — Ohio Revised Code § 3923.84 (enacted by HB 463 in 2017; last updated February 18, 2025):

Provision	Statutory Requirement
Applicable Plans	Individual and group sickness and accident insurance policies delivered, issued, or renewed in Ohio; excludes non-grandfathered individual and small group market plans (covered under ACA EHB requirements); excludes Medicare supplement, accident-only, and other limited benefit policies
Age Limits	Mandatory minimums apply for children *under age 14*; ASD coverage generally required through *age 21*
Dollar Caps	None — statute requires parity: coverage shall not be "subject to dollar limits, deductibles, copayments, and other cost-sharing conditions less favorable than those for substantially all medical and surgical benefits"
Weekly Hour Limits	*ABA (Clinical Therapeutic Intervention): 20 hours/week* (for children under age 14)

Provision	Statutory Requirement
Other Service Limits	Speech/language therapy: 20 visits/year (under age 14); OT: 20 visits/year (under age 14); Mental/behavioral health outpatient: 30 visits/year (under age 14)
Services Covered	Screening, diagnosis, and treatment of ASD; "clinical therapeutic intervention" including (but not limited to) ABA; pharmacy, psychiatric, psychological, and therapeutic care
Prior Authorization	Required; services must be prescribed/ordered by a psychologist trained in autism, developmental pediatrician, or CNS/CNP specializing in pediatric health
Annual Review	Treatment plan may be reviewed annually (or more frequently if agreed by insurer and treating provider); insurer covers cost of review
Provider Requirements	Certified Ohio Behavior Analyst (COBA) designation required; COBA requirements can be satisfied by BCBA qualifications; Ohio Board of Psychology oversight
IDEA Non-Duplication	Does not limit IDEA/IEP/IFSP obligations or otherwise available benefits
ASO Plans	Mandate does NOT apply; criteria of this policy apply

MHPAEA Parity Analysis (Fully Insured Plans): The 20-hours/week ABA limit for children under age 14 is a Quantitative Treatment Limitation (QTL) under MHPAEA. This limit may be unenforceable for fully insured plans subject to MHPAEA where no equivalent weekly service hour limit applies to comparable medical/surgical benefits. *Curative Health Plan will evaluate MHPAEA compliance before applying the Ohio 20-hour/week cap and age-21 limit to MHPAEA-covered fully insured plans.* Ohio's own statutory parity language ("coverage shall not be subject to dollar limits... less favorable than those for substantially all medical and surgical benefits") supports this analysis.

BH/Mental Health Parity: Ohio ORC § 3923.84 includes explicit parity language requiring that ASD-related cost-sharing shall not be less favorable than for medical/surgical benefits. Ohio Medicaid covers ABA without age restriction or dollar limit (distinct from commercial mandate provisions).

7I. State Mandate Summary Table

State	Statute	ABA Age Limit	ABA Dollar Cap	Lifetime Cap	Weekly Hour Cap	Diagnosis-by-Age Req.	BCBA State Licensure	MHPAEA Cap Override Risk	ECT Special Requirements
TX	IC § 1355.015	None (must diagnose before age 10)	$36,000/yr (age 10+); None (under 10)	None	None	Before age 10	Yes (TDLR, 2017)	High	Additional physician attestation required

State	Statute	ABA Age Limit	ABA Dollar Cap	Lifetime Cap	Weekly Hour Cap	Diagnosis-by-Age Req.	BCBA State Licensure	MHPAEA Cap Override Risk	ECT Special Requirements
FL	FS § 627.6686	Under 18 (or 18+ if in HS)	$36,000/yr	$200,000	None	By age 8	No (§ 393.17)	High	None specific to FL
GA	GA § 33-24-59.10	Under 21	$35,000/yr	None	None	None	Yes (GBALB, 2022)	High	None specific to GA
DC	DC Code § 31-3271	*None*	*None*	*None*	None	None	Yes (DC BOP, 2024)	Low–Moderate	None specific to DC
MD	MD Ins. § 15-835	*None*	*None*	*None*	Floors only: 25 hrs (<6 yrs); 10 hrs (6–18 yrs) — minimums, not ceilings	None	Yes (MSBPCT, 2014)	Low	None specific to MD
IN	IC § 27-8-14.2	*None* (commercial)	*None* (commercial)	None	None (commercial)	None	Yes (IPLA, 2021)	Low	None specific to IN
OH	ORC § 3923.84	Under 21; mandatory min for under 14	None	None	*20 hrs/week* (under age 14)	None	Yes (OH BOP/COBA, 2013)	High	None specific to OH

All dollar caps and hour limits in the table above are subject to MHPAEA parity analysis for fully insured plans. State mandate provisions that are more restrictive than comparable medical/surgical benefit limits may be superseded by federal MHPAEA requirements. For ASO/self-funded ERISA plans, state mandates do not apply, and the criteria of this policy govern.

SECTION 8: APPLICABLE DIAGNOSIS CODES (ICD-10-CM)

8A. ASD Diagnoses (Qualifying for ABA Under This Policy)

ICD-10-CM Code	Description	Notes
F84.0	Autistic disorder	Primary applicable code; corresponds to DSM-5-TR Autism Spectrum Disorder

ICD-10-CM Code	Description	Notes
F84.5	Asperger's syndrome	DSM-5-TR subsumes Asperger's into ASD; some legacy diagnoses may use F84.5; covered under this policy
F84.8	Other pervasive developmental disorders	Includes atypical autism and other PDD presentations that meet DSM-5-TR ASD criteria; covered
F84.9	Pervasive developmental disorder, unspecified	Used when ASD diagnosis is established but specific subtype is unspecified; covered

8B. ASD Diagnoses NOT Qualifying for ABA Under This Policy

ICD-10-CM Code	Description	Reason Not Covered
F84.2	Rett's disorder (Rett syndrome)	Rett syndrome is NOT classified as Autism Spectrum Disorder under DSM-5-TR; distinct genetic etiology (MECP2 mutation)
F84.3	Other childhood disintegrative disorder	Childhood disintegrative disorder is NOT classified as ASD under DSM-5-TR

8C. Additional BH Diagnosis Codes

ICD-10 Code	Description
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.3	Major depressive disorder, single episode, severe with psychotic features
F33.0	Major depressive disorder, recurrent, mild
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressive disorder, recurrent, severe without psychotic features
F33.3	Major depressive disorder, recurrent, severe with psychotic features
F70	Mild intellectual disabilities
F71	Moderate intellectual disabilities
F72	Severe intellectual disabilities
F73	Profound intellectual disabilities

ICD-10 Code	Description
F90.0	Attention-deficit hyperactivity disorder, predominantly inattentive type
F90.1	Attention-deficit hyperactivity disorder, predominantly hyperactive type
F90.2	Attention-deficit hyperactivity disorder, combined type
F41.0	Panic disorder
F41.1	Generalized anxiety disorder
F42.2	Mixed obsessional thoughts and acts (OCD)
F42.8	Other obsessive-compulsive disorder
F43.10	Post-traumatic stress disorder, unspecified
F43.11	Post-traumatic stress disorder, acute
F43.12	Post-traumatic stress disorder, chronic
F31.0	Bipolar disorder, current episode hypomanic
F31.1	Bipolar disorder, current episode manic without psychotic features
F31.2	Bipolar disorder, current episode manic with psychotic features
F31.4	Bipolar disorder, current episode depressed, mild or moderate severity
F31.5	Bipolar disorder, current episode depressed, severe, without psychotic features
F31.6	Bipolar disorder, current episode depressed, severe, with psychotic features
F20.0	Paranoid schizophrenia
F20.9	Schizophrenia, unspecified
F25.0	Schizoaffective disorder, bipolar type
F25.1	Schizoaffective disorder, depressive type
F44.2	Dissociative stupor (catatonia)
F50.00	Anorexia nervosa, unspecified
F50.01	Anorexia nervosa, restricting type
F50.02	Anorexia nervosa, binge eating/purging type
F50.2	Bulimia nervosa
F10.10	Alcohol use disorder, mild
F10.20	Alcohol use disorder, moderate

ICD-10 Code	Description
F11.10	Opioid use disorder, mild
F11.20	Opioid use disorder, moderate
F12.10	Cannabis use disorder, mild
F12.20	Cannabis use disorder, moderate
F14.10	Cocaine use disorder, mild
F19.10	Other psychoactive substance use disorder, mild
F91.1	Conduct disorder, childhood-onset type
F93.0	Separation anxiety disorder of childhood
F94.0	Selective mutism
F95.2	Tourette's disorder

8D. Common Co-Occurring Diagnosis Codes (ABA Context — Not Independently Qualifying)

ICD-10-CM Code	Description
F70–F79	Intellectual disabilities (may co-occur with ASD)
F80.x	Specific developmental disorders of speech and language
F90.x	Attention-deficit hyperactivity disorders
F41.x	Anxiety disorders
F42.x	Obsessive-compulsive disorder
R48.8	Other symbolic dysfunctions (including hyperlexia)

These codes do not independently qualify for ABA coverage under this policy. Members with these diagnoses and a co-occurring ASD diagnosis (F84.0, F84.5, F84.8, or F84.9) may receive ABA coverage for services addressing the ASD diagnosis.

SECTION 9: REVISION HISTORY

Version	Date	Author	Description
1.0	March 21, 2026	Clinical Policy — Curative Health Plan	Initial policy creation. Covers PA categories 1–8 for members under 18.

Version	Date	Author	Description
2.0	April 27, 2026	Clinical Policy — Curative Health Plan	Replaced original ABA section with comprehensive ABA Therapy content from CHP-BEH-2026-003 v2.0. Integrated full ABA medical necessity criteria, supervision requirements (10% BCBA supervision ratio, 2 face-to-face contacts/month), mandatory caregiver participation (1–4 hrs/month, 80% threshold), required assessment tools (Vineland-3, VB-MAPP/ABLLS-R/AFLS, ADOS-2/ADI-R, FBA), maximum weekly hour caps (40/30/25/20 by age), telehealth code-specific rules, expanded exclusions list, concurrent billing restrictions, and detailed state mandate analysis for all 7 operating states. Added SECTION 4[Z] (ABA MEETS CRITERIA) and SECTION 5[Z] (ABA DOES NOT MEET CRITERIA) as comprehensive new sections. Integrated ABA-specific state mandate detail (Texas § 1355.015, Florida § 627.6686, Georgia Ava's Law § 33-24-59.10, DC § 31-3271, Maryland § 15-835, Indiana IC § 27-8-14.2 with Medicaid/commercial distinction, Ohio ORC § 3923.84) into Section 7 alongside existing BH mandate framework. Updated ICD-10 section to separately identify qualifying ASD diagnosis codes (F84.0, F84.5, F84.8, F84.9), non-qualifying ASD codes (F84.2, F84.3), and ABA co-occurring diagnoses. Updated policy version to 2.0; Last Reviewed Date updated to April 27, 2026.

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This policy is intended for use by licensed clinical reviewers and AI-assisted prior authorization systems. All authorization decisions are subject to the member's specific benefit plan terms. This policy was developed by the Clinical Policy Committee of Curative Health Plan. The ABA criteria in Sections 4[Z] and 5[Z] (Version 2.0) reflect standards derived from published clinical guidelines (BACB, CASP, AAP, AACAP) and peer-reviewed evidence, as sourced from CHP-BEH-2026-003 v2.0. All state statute provisions should be verified against current law at time of claim adjudication. MHPAEA analysis within this policy does not constitute legal advice; Curative Health Plan's legal and compliance counsel should be consulted before finalizing coverage determinations in individual cases.