CURATIVE HEALTH PLAN

Medical Policy

Behavioral Health and Substance Use Disorder Services

Members 18 and Over

Version 2.0

Policy Number	CHP-BEH-2026-002
Policy Title	Behavioral Health and Substance Use Disorder Services (Members 18 and Over)
Effective Date	April 1, 2026
Last Reviewed Date	April 27, 2026
Next Review Date	April 27, 2027
Applies To	Level Funded, Fully Insured, ASO
States	TX, FL, GA, DC, MD, IN, OH
Age Group	18 and Over
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 psychiatry. Medical necessity determinations must be made on a case-by-case basis using all available clinical information.

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 18 years of age and older 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 for Autism Spectrum Disorder (adults 18 and over), behavioral health evaluations, transcranial magnetic stimulation (TMS), and electroconvulsive therapy (ECT).

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

- *APA Clinical Practice Guidelines* (American Psychiatric Association) — standard of care for adult psychiatric diagnosis and treatment
- *LOCUS* (Level of Care Utilization System) — adult mental health level of care placement framework for members aged 18 and older
- *ASAM Criteria, 4th Edition (2023)* (American Society of Addiction Medicine) — for substance use disorder level of care placement across all ages
- *BACB ABA Practice Guidelines* — Behavior Analyst Certification Board standards for applied behavior analysis
- *CASP ABA Practice Guidelines Version 3.0 (2024)* — Council of Autism Service Providers
- *APA/NNDC Consensus Recommendations* — rTMS clinical application consensus, Journal of Clinical Psychiatry (PMC5846193)

Mental Health Parity and Addiction Equity Act (MHPAEA) compliance: 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.

SECTION 3: APPLICABLE CPT/HCPCS CODES

3A. ABA Therapy Codes

CPT/HCPCS Code	Description	Qualified Provider	Unit
0362T	Exposure behavioral follow-up assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administered by technician(s) under the direction of a physician or other qualified health care professional, with the physician or other qualified health care professional on-site; for a patient requiring two or more simultaneous technicians	BCBA-D or BCBA (supervising, physically on-site); BCaBA/RBT (administering); *in-person only — telehealth not permitted*	15-min units
0373T	Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; for a patient requiring two or more simultaneous technicians; requiring the following components: administered by technician(s) under the direction of a physician or other qualified health care professional, with the physician or other qualified health care professional on-site	BCBA-D or BCBA (supervising, physically on-site); BCaBA/RBT (administering); *in-person only — telehealth not permitted*	15-min units (sum of all technician time)
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 standardized and non-standardized instruments	BCBA-D, BCBA, or licensed MH provider; *billable via telehealth*	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; *in-person only — telehealth not permitted*	15-min units
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional and directed by physician or other qualified health care professional, face-to-face with one patient; each 15 minutes	BCBA-D, BCBA, or licensed MH provider (patient must be present); *billable via telehealth*	15-min units

CPT/HCPCS Code	Description	Qualified Provider	Unit
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; *billable via telehealth*	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; patient must NOT be present; *billable via telehealth*	15-min units per caregiver group per patient
97158	Group adaptive behavior treatment by protocol, 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; *in-person required; billable via telehealth per code rules*	15-min units per patient

Note: CPT code 97152 (observational behavioral follow-up assessment by technician) does not require prior authorization as a standalone observation code but must be supervised by a BCBA-D, BCBA, or licensed MH provider; typically capped at 8–32 units per assessment. 97154 (group adaptive behavior treatment by protocol — technician) similarly does not require PA and must be supervised appropriately. Both 97152 and 97154 require in-person delivery; telehealth is not permitted.

Concurrent Billing Rules — 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

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
- `0373T` billing = sum of all technician time (e.g., 3 technicians × 3 hours = 36 units)

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 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; each additional hour	Physician, psychologist, or other QHP (add-on to 96112)
`96125`	Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) 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
`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 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; each additional hour	Physician or QHP (add-on to 96130)

CPT/HCPCS Code	Description	Provider Type
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 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; each additional hour	Physician or QHP (add-on to 96132)
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	Physician or QHP (add-on to 96136)
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	Technician under QHP supervision (add-on to 96138)
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
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

CPT/HCPCS Code	Description	Notes
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)
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
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

CPT/HCPCS Code	Description
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

CPT/HCPCS Code	Description
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 (ADULTS 18 AND OVER)

This section governs all prior authorization requests for ABA therapy codes (0362T, 0373T, 97151, 97153, 97155, 97156, 97157, 97158) for members 18 years of age and older. All content in this section is specific to adult members and supersedes the original ABA section of Version 1.0 of this policy.

4Z-A: Universal Prerequisites

ALL of the following criteria must be met for authorization of any ABA service for members 18 and over:

4Z-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), established by a qualified evaluating provider. For adult members (18+), ASD diagnosis is well-established by adulthood; the qualifying diagnosing providers include: developmental pediatrician, board-certified psychiatrist, licensed psychologist (PhD or PsyD), licensed clinical neurologist with documented ASD assessment training, or other physician (MD/DO) with documented expertise in ASD diagnosis and assessment.

4Z-A.2 The ASD diagnosis was established through a comprehensive diagnostic evaluation using DSM-5-TR criteria. For adult members whose original childhood diagnosis was made using DSM-IV or ICD-10 criteria, documentation establishing that the diagnosis meets DSM-5-TR criteria for ASD is sufficient. If the member has never received a formal evaluation using validated instruments, a current evaluation by a qualified provider is required before ABA authorization.

4Z-A.3 The comprehensive diagnostic evaluation that established the ASD diagnosis 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 for ABA authorization.

4Z-A.4 — Diagnostic Evaluation Currency (36-Month Requirement): 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 and to confirm that ASD remains the clinically appropriate diagnosis for treatment planning purposes.

4Z-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 [AAC] for social purposes)

- Adaptive behavior (daily living skills: self-care, domestic, community participation, health management)
- Behavior regulation (presence of interfering behaviors: self-injurious behavior, aggression, property destruction, stereotypy, elopement, or ritualistic/restrictive behaviors that impair community functioning or employment)
- Communication (receptive or expressive language deficits relative to functional expectations)
- Vocational or occupational functioning impacted by ASD-related deficits
- Independent living skills (functional deficits in self-care, domestic management, community safety)

For adult members, functional impairment must be documented with specific, objective information — frequency counts, adaptive behavior assessment scores, caregiver reports, vocational evaluations, or other concrete behavioral examples. General narrative descriptions without behavioral specificity are insufficient.

4Z-A.6 The member demonstrates a reasonable expectation of clinical benefit from ABA intervention, defined as: (a) potential for skill acquisition in functional domains; (b) potential for reduction of maladaptive behaviors impairing community participation or safety; (c) maintenance of current adaptive functioning to prevent clinically significant deterioration; or (d) generalization of previously acquired skills to new settings or conditions relevant to adult life.

MHPAEA compliance note: Maintenance of current functional status to prevent clinically significant deterioration is a valid and independent basis for authorizing continued ABA services. CHP does not require measurable improvement as the sole basis for continued authorization.

4Z-A.7 A BCBA-authored individualized Behavior Intervention Plan (BIP) or ABA Treatment Plan, containing all elements specified in Section 4Z-F, is present or will be developed upon authorization of the initial behavior identification assessment (`97151`). For adult members, the treatment plan must specifically address adult-relevant functional targets (see Section 4Z-F).

4Z-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 7Z. Required provider types are:

- `97151`, `97155`, `97156`, `97157`, `97158`: BCBA-D, BCBA, or independently licensed mental health provider credentialed by CHP as a QHP for ABA services
- `97153`: BCaBA or RBT under direction and supervision of BCBA-D or BCBA
- `0362T`, `0373T`: BCaBA/RBT (administering) with BCBA-D or BCBA physically on-site throughout the session
- Supervising BCBA must hold current BACB certification and applicable state licensure per Section 7Z

4Z-A.9 A physician prescription or referral for ABA services is present. Required under Florida mandate § 627.6686, Ohio mandate § 3923.84, and Indiana mandate (physician-approved care plan); strongly recommended for all states as a standard coordination-of-care practice.

4Z-A.10 Member capacity for consent: If the adult member has decision-making capacity, informed consent for ABA treatment must be obtained directly from the member. If the member lacks decision-making capacity (as determined per applicable state law), consent must be obtained from a legally authorized representative (guardian, conservator, healthcare proxy, or power of attorney for healthcare). Documentation of consent or authorized representative status must be in the clinical record.

4Z-B: Treatment Intensity Tiers (Adults 18 and Over)

ABA treatment intensity for adult members must be individually determined based on comprehensive behavioral assessment by the supervising BCBA. Per CASP ABA Practice Guidelines Version 3.0 (2024) and BACB guidance on lifespan ABA, two intensity tiers apply:

Tier	Hours Per Week	Adult Indication
Focused ABA	10–25 hours/week	*Most commonly appropriate for adult members.* Addresses specific, defined behavioral or adaptive skill goals (e.g., functional communication improvement, discrete behavior reduction, vocational skills, independent living skills, social skills for adult settings). Adults with specific, limited behavioral or skill targets — rather than global developmental delays requiring intensive simultaneous intervention across all domains — are most appropriately placed at this tier.
Comprehensive ABA	26–40 hours/week	Less commonly indicated for adults. May be appropriate for adult members with significant functional impairment across multiple domains simultaneously when clinically supported by individualized comprehensive behavioral assessment authored by a BCBA with documented adult ABA competency. Requires documented extraordinary clinical justification for adults.

4Z-B-1: Maximum Weekly Hour Limits (Adults 18 and Over)

The following table reflects the upper limits applied under this policy. These are maximum limits, not entitlements or targets. Actual authorized hours are determined by individualized clinical assessment and documented medical necessity.

Treatment Type	Age	Maximum Hours/Week
Focused ABA	18 and over	*Up to 25 hrs/week*
Comprehensive ABA	18–21 (clinically justified)	Up to 30 hrs/week with documented justification
Comprehensive ABA	22 and over	Up to 25 hrs/week; hours above 25 require extraordinary clinical justification and heightened clinical review

Important Notes on Adult Hour Limits:

- For adults, Focused ABA (up to 25 hrs/week) is the standard upper limit and is appropriate for the vast majority of adult ABA requests.

- Comprehensive hours for adults require specific, documented clinical justification from the supervising BCBA demonstrating global functional deficits across multiple domains and why the adult member's clinical presentation requires comprehensive intensity rather than focused treatment.
- *MHPAEA Compliance:* Hour limits are applied as part of individualized prior authorization review — not as categorical maximum limits independent of medical necessity review.
- 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 for children; Maryland imposes no statutory minimum for adults 19+, but no dollar or hour cap applies.

4Z-C: Required Assessment Tools (Adults 18 and Over)

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. For adult members, instrument selection should prioritize tools validated for adult populations.

4Z-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)* — Module 3 or 4 is typically most appropriate for verbally fluent adults
- *Autism Diagnostic Interview-Revised (ADI-R)* — acceptable as 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.

4Z-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 outcome measure - Vineland-3 results must be documented in the treatment plan and progress report with domain-specific composite scores (Communication, Daily Living Skills, Socialization, Motor Skills)

> The Vineland-3 has published norms through adulthood and is the appropriate adaptive behavior instrument for adult members.

4Z-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. For adult members, the AFLS is most directly aligned with adult functional domains:

- *Assessment of Functional Living Skills (AFLS)* — preferred for adult members; directly assesses vocational, community, and independent living skills
- *Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP)* — appropriate for adults with significant communication deficits
- *Assessment of Basic Language and Learning Skills-Revised (ABLLS-R)* — appropriate for adults with significant language-related treatment targets

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

4Z-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 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

---

4Z-D: Code-Specific Meets Criteria (Adults 18 and Over)

4Z-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 adult member, OR for a periodic reassessment following a 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 credentialed by CHP as a QHP for ABA assessment purposes.
- *[97151-C]* The assessment includes face-to-face time with the adult member 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 update) an individualized BIP or ABA Treatment Plan with adult-specific, measurable, and individualized goals as described in Section 4Z-F, including goals targeting vocational functioning, independent living, community integration, and health and safety behaviors as applicable.
- *[97151-E]* The assessment uses validated behavioral assessment instruments as specified in Section 4Z-C, including Vineland-3 at baseline and each 6-month reassessment, and at least one criterion-referenced instrument (AFLS preferred; VB-MAPP or ABLLS-R also acceptable).
- *[97151-F]* 97151 is billed at initial evaluation and at periodic reassessments — not weekly or for routine daily/weekly treatment adjustments.
- *[97151-G] Billable via telehealth* for adult members when clinically appropriate and state-specific telehealth requirements are met.

Standard authorization parameters for adults: Initial assessment up to 8 units (2 hours)/day; total initial assessment typically 16–32 units (4–8 hours); periodic reassessment typically 12–24 units. Additional units require clinical justification.

4Z-D.2 — 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, addressing functional deficits relevant to the adult member's life (vocational, independent living, community integration, behavioral safety).
- *[97153-C]* The technician (BCaBA or RBT) is implementing the approved BCBA-authored protocol as written, without modification.
- *[97153-D]* The supervising BCBA maintains supervision documentation demonstrating a *minimum 10% supervision ratio* of the technician's direct treatment hours per month, 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.
- *[97153-E]* Objective behavioral data is collected and documented for each treatment session.
- *[97153-F]* Active treatment has a realistic expectation of clinical benefit for the adult member.
- *[97153-G] In-person delivery required; telehealth is NOT permitted for* 97153.

4Z-D.3 — 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 adult member 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 adult member and modifying protocol components in real time; (b) the QHP is directing a technician on new or modified protocol components while the member is present; (c) the QHP is directly observing member-technician interaction and troubleshooting protocol implementation, with documented clinical rationale.
- *[97155-C]* The session produces documented modifications, observations, or clinical decisions incorporated into the member's BIP.
- *[97155-D]* 97155 is not billed concurrently with 0373T.
- *[97155-E]* When 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.
- *[97155-F] Billable via telehealth* when clinically appropriate; in-person is not required for 97155.

4Z-D.4 — CPT 97156 (Family/Caregiver 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/support person training directly related to the adult member's active ABA treatment plan.
- *[97156-B]* The training content addresses implementation of ABA-based procedures applicable to supporting the adult member's behavioral goals in natural environments (home, community, workplace).
- *[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 adult member's ABA program in natural settings. For adult members, "caregiver" may include: parent or family member of an adult with ASD, legally authorized representative (guardian, conservator), residential support staff, job coach, spouse or domestic partner, or other individual with regular supportive contact in the member's life.
- *[97156-E]* The adult member's participation or non-participation in caregiver training sessions is consistent with their consent and wishes. For adults with decision-making capacity, the member's agreement to involve specific support persons in treatment must be documented.
- *[97156-F]* When the adult member 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/support person participation requirements in Section 4Z-G (minimum 1–4 hours/month).
- *[97156-H] Billable via telehealth* when clinically appropriate.

4Z-D.5 — CPT 97157 (Multiple-Family/Caregiver Group Adaptive Behavior Treatment Guidance — QHP)

MEETS CRITERIA when ALL of the following are true:

- *[97157-A]* All criteria for 97156 (4Z-D.4 above) apply.
- *[97157-B]* Two or more sets of caregiver/support person groups are receiving training simultaneously from the QHP.
- *[97157-C]* The adult member is NOT present during 97157 services (member absence is required).
- *[97157-D]* Services are billed per set of caregivers per patient.
- *[97157-E]* Group size does not exceed 8 caregiver groups per session.
- *[97157-F] Billable via telehealth* when clinically appropriate.

4Z-D.6 — 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 adult members.
- *[97158-C]* Clinical justification for QHP-led group format is documented (e.g., social skills training for adult employment settings, group behavioral skill development, peer modeling for adult vocational goals).
- *[97158-D]* Each adult member in the group has individualized behavioral goals appropriately addressed within the group context.
- *[97158-E]* `97158` is not billed concurrently with a technician-led group code for the same patient group in the same session.
- *[97158-F]* `97158` is billed per patient.

4Z-D.7 — CPT `0362T` (Behavior Identification Supporting Assessment — Destructive Behavior, Category III)

MEETS CRITERIA when ALL of the following are true:

- *[0362T-A]* The adult 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 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 adult member and technicians.
- *[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] In-person delivery required;* `0362T` *is not billable via telehealth.*

4Z-D.8 — 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 (4Z-D.7 above) are met (destructive behavior documented; two or more technicians; customized environment; QHP physically 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.
- *[0373T-F] In-person delivery required;* 0373T *is not billable via telehealth.*

4Z-E: Supervision Requirements (Adults 18 and Over)

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

4Z-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 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; at least one contact per month must include in-person or synchronous real-time observation of the RBT delivering treatment to the adult member
- 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

4Z-E.2 — BCaBA Supervision:

- BCaBA 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)
- 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 oversight of any RBTs under their supervision AND the BCBA's supervision of the BCaBA

4Z-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. Requests for hours that exceed the BCBA's supervisory capacity as evidenced by supervision documentation will be flagged for clinical review.

4Z-F: Required Treatment Plan Elements (Adults 18 and Over — Adult-Specific Focus)

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. For adult members (18+), treatment plan goals must specifically reflect the member's adult functional context.

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 4Z-A.4). Member consent documentation status (see 4Z-A.10).

2. *Baseline Data:* Objective, quantitative baseline measurement for each behavioral target and skill acquisition program — expressed in measurable terms (frequency per hour, percentage of trials correct, duration in seconds, intensity rating, latency to response). Vineland-3 baseline scores required per Section 4Z-C.2.

3. *SMART Goals — Adult-Specific Emphasis:* 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* with at least 2 different therapists and in at least 2 different settings or conditions, unless documented clinical rationale supports a different criterion - The projected timeline for mastery - The clinical rationale for including the goal - *Adult-Specific Goal Categories* — treatment goals for adult members must specifically address one or more of the following functional domains: *Vocational skills:* Job readiness behaviors, workplace social communication, adherence to work routines, reduction of behaviors that interfere with employment, job site skill development *Independent living:* Self-care (hygiene, health management), domestic skills (meal preparation, housekeeping, financial management basics), community navigation (public transportation, shopping, banking) *Community integration:* Community safety behaviors, social skills for adult public settings, utilization of community resources *Communication:* Functional communication (including AAC if applicable), communication in adult contexts (medical appointments, employment settings, social relationships) *Behavior reduction:* Reduction of self-injurious behaviors, aggression, or other interfering behaviors that limit community participation, employment, or safety

Health and safety: Self-management of medical care participation, medication adherence (behavioral support), health and safety behaviors in community settings

4. *Evidence-Based Intervention Strategies:* Specific ABA-based intervention strategies identified for each goal, drawn from 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 appropriate for adult learners.

5. *Treatment Intensity Justification:* Requested hours per week with clinical rationale tied to the adult member's individual presentation, number and complexity of treatment targets, and applicable evidence base. Hours requested must be consistent with the adult maximum limits in Section 4Z-B-1 or include documented extraordinary clinical justification for any excess.

6. *Treatment Setting:* Clinic, home, community, or workplace setting with clinical rationale for the recommended setting(s). Adult community settings (workplace, community organizations, adult day programs) are clinically appropriate settings for adult ABA services.

7. *Caregiver/Support Person Involvement Plan (Adult-Specific):* Per Section 4Z-G, involvement of appropriate support persons in ABA treatment is mandatory where the adult member consents. The treatment plan must document: - Identity and relationship of the identified support person(s) (parent, guardian, spouse, residential staff, job coach) - Member's consent to involve identified support person(s) - Caregiver/support person training goals with measurable competency targets - Planned frequency and format of `97156`/`97157` family guidance sessions (minimum 1–4 hours/month) - Measurable support-person-implemented goals carried out in natural environments - Plan for monitoring support person attendance (≥80% of scheduled sessions required) - Documentation of barriers to support person involvement and accommodations offered, where applicable - Where the adult member lacks appropriate support persons in their life, this must be documented and alternative community-based generalization strategies identified

8. *Generalization and Maintenance Plan:* Explicit strategies for promoting skill generalization across settings (clinic → home → workplace → community), people, and conditions; maintenance programming; natural environment training components.

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

10. *Coordination of Care Documentation:* Documentation of communication with and/or referral to: speech-language pathologist, occupational therapist, physical therapist, primary care physician, psychiatrist, vocational rehabilitation specialist, residential support coordinator, and/or other relevant providers as applicable to the adult 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; 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 independence or support-person competency.

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

4Z-G: Caregiver/Support Person Involvement — Adult-Specific Application

Involvement of appropriate support persons in ABA therapy is *mandatory where clinically appropriate and where the adult member consents*, supported by the clinical evidence base establishing caregiver/support person-mediated ABA as an evidence-based practice for skill generalization.

4Z-G.1 — Adult-Specific Framework:

For adult members (18+), "caregiver" is broadly construed to include any individual who provides regular supportive contact in the member's daily life and is in a position to implement ABA strategies in natural environments. This includes but is not limited to:

- *Parent or family member* of an adult with ASD (commonly the primary support person for adults who live with family)
- *Spouse or domestic partner* of the adult member
- *Legal guardian or conservator* (authorized to make decisions and participate in treatment on the member's behalf)
- *Residential support staff* (if the member lives in a supported residential setting)
- *Job coach or employment specialist* (for vocational ABA goals)
- *Adult day program staff* (where applicable)

For adult members with decision-making capacity, *the member's informed consent to involve specific support persons is required*. If an adult member does not consent to involvement of specific support persons, or does not have identifiable support persons, the provider must document this and develop alternative strategies for skill generalization (community-based training, clinic-to-community generalization).

4Z-G.2 — Participation Requirements:

- *Minimum frequency:* Support persons must participate in a minimum of *1–4 hours per month* of support person training (billable under CPT `97156` or `97157`) as a component of the adult member's authorized ABA program
- *Attendance standard:* Support person attendance/participation must be documented at *≥80% of scheduled training sessions* per authorization period
- *Measurable goals:* The treatment plan must include at least one measurable support-person-implemented goal with competency data collected

4Z-G.3 — Documentation of Support Person Participation: Provider session notes and the treatment plan update must document:

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

4Z-G.4 — Failure to Meet Participation Threshold:

- If support person attendance falls below 80% of scheduled sessions, the provider must first document the barriers encountered and accommodations offered
- Where barriers are identified, documented accommodations (schedule flexibility, telehealth sessions for support person training, interpreter services) must be attempted before any reduction in authorization is considered
- Failure of support person involvement alone is *NOT* grounds for termination of the adult member's entire ABA program. The clinical impact must be individually assessed. Adults who lack available support persons, or who do not consent to support person involvement, may still receive medically necessary ABA services with alternative generalization strategies.

4Z-G.5 — MHPAEA Compliance: CHP applies support person participation requirements as a clinical standard of care rather than an absolute condition of authorization. CHP evaluates MHPAEA compliance in the application of participation requirements and maintains comparative analysis confirming that equivalent standards are applied to comparable medical/surgical benefits.

4Z-H: Setting Requirements (Adults 18 and Over)

4Z-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, support person training, and natural environment teaching
- *Clinic/Center:* Clinic or ABA center-based treatment for structured skill acquisition programs
- *Community:* Community-based ABA (workplace, grocery store, community organizations, public transportation, adult day settings) for generalization training in natural settings relevant to adult functioning, with documented clinical justification for community setting goals
- *Supported employment/vocational settings:* ABA delivered in or adjacent to a vocational or employment setting to support workplace skill development, with documented clinical justification

4Z-H.2 — Telehealth: Code-specific telehealth rules apply as described in Section 3A:

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

4Z-I: Progress Requirements (Adults 18 and Over)

4Z-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.

4Z-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 (inadequate supervision, insufficient support person participation, need for plan revision)
- Whether the adult member's functional status 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, a plan-of-care conference with the BCBA and member (and support persons where appropriate) is required before discontinuing services

4Z-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, demonstrating change over the authorization period
- *At least one criterion-referenced measure:* AFLS, VB-MAPP, or ABLLS-R — 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)

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

- Treatment goals have been mastered (per 4Z-I.1 mastery criteria)
- Mastered skills have been demonstrated with *generalization* across settings, people, and conditions relevant to the adult member's daily life
- *Support person/community independence* in implementing strategies has been achieved and documented

- The adult member's adaptive functioning level no longer requires BCBA-supervised intervention to maintain

---

4Z-J: Reauthorization Criteria (Adults 18 and Over)

Authorization periods for adult 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 (AFLS preferred for adults; VB-MAPP or ABLLS-R also acceptable) per Section 4Z-C.

ALL of the following must be documented for reauthorization:

4Z-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, with adult-functional relevance documented

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

- Continued skill acquisition toward independence in targeted adult functional 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, community participation, or pose safety risk
- Generalization training to extend previously acquired skills to new adult settings, people, or conditions
- Transition planning for vocational, independent living, or community environments

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

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

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

4Z-J.4 Support person engagement documentation demonstrating:

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

4Z-J.5 Updated coordination of care statement noting changes in residential placement, vocational program, SLP/OT/PT services, psychiatric medications, or other relevant concurrent services.

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

4Z-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)
- Support person training completion rates
- Plan for transition/discharge with projected timeline and discharge criteria

---

4Z-K: Age-Specific Criteria (18 and Over)

Ages 18–21 Years — Young Adult ABA

4Z-K.1 ABA for members ages 18–21 is medically necessary when Universal Prerequisites (Section 4Z-A) and code-specific criteria (Section 4Z-D) are met. Focused ABA (10–25 hours/week) is most commonly appropriate; comprehensive hours require documented clinical justification.

4Z-K.2 Treatment plans for members ages 18–21 must emphasize adult-transition-focused goals:

- *Vocational skills:* Job readiness, workplace social communication, employment setting behavior
- *Independent living:* Self-care, domestic skills, community navigation, financial basics

- *Reduction of maladaptive behaviors* that limit community participation or employment
- *Social skills* for adult settings (post-secondary education, workplace, community)
- *Transition from secondary to post-secondary* educational or vocational settings

4Z-K.3 For members ages 18–21 who have recently transitioned out of secondary education (or will do so within the authorization period), the treatment plan must address transition from school-based supports to adult community services, with coordination of care documentation reflecting engagement with vocational rehabilitation services, adult residential services, or post-secondary programs as appropriate.

4Z-K.4 For members ages 18–21 on fully insured plans, state mandate applicability must be assessed per Section 7Z:

- *Texas* § 1355.015: No maximum age cap, but diagnosis must have been established before the member's 10th birthday; $36,000/year cap for members age 10+ (subject to MHPAEA analysis)
- *Florida* § 627.6686: Coverage for members "under age 18 OR age 18+ if still enrolled in high school"; coverage for members 18–21 who are not in high school is not state-mandated but may be required by MHPAEA
- *Georgia* § 33-24-59.10 (Ava's Law): Coverage required for members "under age 21" — members ages 18–20 are covered under the Georgia mandate; members age 21+ are not state-mandated (subject to MHPAEA analysis)
- *DC* § 31-3271: No age limit — fully insured DC plans must cover ABA for members of all ages including 18–21
- *Maryland* § 15-835: No age limit — fully insured MD plans must cover ABA for members of all ages including 18–21
- *Indiana* IC § 27-8-14.2: No age limit for commercial plans — fully insured IN plans must cover ABA for members of all ages including 18–21
- *Ohio* ORC § 3923.84: Coverage generally required through age 21 — members ages 18–20 are covered under the Ohio mandate; members age 21+ are not state-mandated (subject to MHPAEA analysis)

Ages 22 and Older — Adult ABA

4Z-K.5 ABA for adult members age 22 and older is medically necessary when Universal Prerequisites (4Z-A) are met and the treatment plan documents:

- Specific, measurable behavioral goals addressing functional deficits that limit independence, community participation, safety, or quality of life
- Clinical rationale for why ABA methodology is the appropriate intervention for the member's specific treatment targets
- Reasonable expectation of benefit, including maintenance of current functional status to prevent clinically significant deterioration
- Supervising BCBA with documented competency in adult ABA service delivery

4Z-K.6 For adult members age 22 and older, the clinical evidence base is well-established for ABA interventions targeting: adaptive behavior skills, reduction of self-injurious or aggressive behavior, communication training (including AAC implementation), daily living skills, and community integration skills. Authorization criteria for adults 22+ apply a *more rigorous documentation standard* compared to younger age groups, reflecting the emerging (but growing) adult-specific evidence base, while recognizing that MHPAEA prohibits categorical exclusion of adult ABA coverage.

4Z-K.7 Adult ABA for members age 22+ on fully insured plans is subject to the following state mandate analysis:

- *Texas* § 1355.015: No age cap, but requires diagnosis before 10th birthday for mandate to apply; $36,000/year cap for adults diagnosed before age 10 (subject to MHPAEA analysis)
- *Florida* § 627.6686: Mandate does not apply to adults 22+ who are not in high school; MHPAEA parity analysis determines coverage obligation
- *Georgia* § 33-24-59.10 (Ava's Law): Mandate does not apply to members age 21+; MHPAEA parity analysis determines coverage obligation for fully insured plans
- *DC* § 31-3271: No age limit — fully insured DC plans must cover ABA for adults of all ages
- *Maryland* § 15-835: No age limit — fully insured MD plans must cover ABA for adults of all ages, with no dollar caps
- *Indiana* IC § 27-8-14.2: No age limit for commercial plans — fully insured IN plans must cover ABA for adults of all ages
- *Ohio* ORC § 3923.84: Mandate does not apply to members age 21+; MHPAEA parity analysis determines coverage obligation for fully insured plans

4Z-K.8 — MHPAEA Coverage Obligation for Adults Age 21+/22+ Where State Mandate Does Not Apply: For fully insured plans in states where the state mandate does not cover adults 21+ or 22+ (Texas, Florida, Georgia, Ohio), CHP evaluates MHPAEA parity before applying any age-based exclusion. If comparable medical/surgical benefits under the same plan do not impose equivalent age restrictions, the age restriction on ABA coverage may constitute an impermissible NQTL under MHPAEA. CHP does not apply categorical age cutoffs to adult ABA coverage for fully insured plans subject to MHPAEA without documented comparable medical/surgical age limits.

4Z-L: Concurrent Services (Adults 18 and Over)

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

4Z-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.

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

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

- Communication with all concurrent service providers (written or documented verbal)
- Summary of each provider's current goals and the member's progress
- Confirmation of non-duplication of services

4Z-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.

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

4Z-L.6 For adult members, concurrent vocational rehabilitation services, supported employment programs, or adult day program services may co-occur with ABA. ABA goals must be complementary to (not duplicative of) vocational rehabilitation program goals; coordination documentation is required quarterly.

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

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

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

All of the following must be met:

1. The member presents with new, worsening, or significantly changed psychiatric or SUD 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 and substance use history b. Mental status examination (orientation, affect, thought process and content, judgment, insight, suicidality/homicidality) c. Past psychiatric treatment history and treatment response d. Social, occupational, and functional history e. Differential diagnosis f. Preliminary treatment recommendations or treatment plan

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. A single encounter is typically sufficient for adults; multiple sessions require documented clinical justification.

6. 90791 and 90792 shall not be billed by the same provider on the same date of service.

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

All of the following must be met:

1. The evaluation is performed by a psychiatrist or other MD/DO.

2. The evaluation includes a medical assessment component in addition to the psychiatric evaluation: a. Review of medical history and current medications relevant to psychiatric presentation b. Mental status examination c. Assessment of medical differential diagnoses contributing to psychiatric symptoms d. Medication evaluation, initiation, or management considerations

3. Indication criteria are identical to `90791` above.

4. For adult members, common indications include: new psychiatric presentation, first presentation to psychiatrist, significant psychiatric decompensation, complex medical-psychiatric comorbidity evaluation, medication initiation requiring comprehensive evaluation.

4B.2 Psychological and Neuropsychological Testing

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

1. Member presents with concerns regarding cognitive development, adaptive behavior, or developmental history relevant to current clinical treatment planning.

2. Standardized developmental instruments are used (e.g., Vineland-3, Adaptive Behavior Assessment System).

3. In adult members, `96112`/`96121` is less commonly used than `96130`–`96133`; appropriate when developmental assessment instruments are the predominant testing modality.

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

1. Testing is medically necessary for at least one of the following: a. Differential diagnosis of psychiatric disorders with similar presentations (e.g., MDD vs. bipolar, ADHD vs. depression, personality disorder assessment) b. Cognitive assessment for suspected dementia or mild cognitive impairment (MCI) c. Evaluation of cognitive effects of psychiatric illness, substance use, or medical condition d. Pre-surgical or pre-treatment cognitive baseline (e.g., pre-ECT, pre-chemotherapy) e. Assessment of TBI-related cognitive deficits f. Planning and monitoring of cognitive rehabilitation g. Occupational fitness or disability determination when cognitive assessment is clinically necessary (not solely for administrative purpose)

2. Testing uses standardized instruments with national normative data.

3. `96130` and `96132` are mutually exclusive in the same testing episode.

4. Evaluation codes must be accompanied by corresponding test administration codes (`96136`/`96137`, `96138`/`96139`, or `96146`).

5. Authorization is typically limited to once per calendar year per testing type; repeat testing within 12 months requires documented clinical justification.

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

1. Physician or QHP directly administers and scores two or more tests.
2. Must be billed with corresponding evaluation code.

96138/96139 — *Test Administration by Technician:*

1. Trained technician administers and scores tests under QHP supervision.
2. All evaluation and interpretation performed by supervising QHP.

96125 — *Standardized Cognitive Performance Testing:*

1. Specific standardized cognitive performance instrument is used.
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. Once per date of service.

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

4C.1 TMS — FDA-Cleared Primary Indication: Major Depressive Disorder (MDD)

All of the following criteria must be met:

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

2. *Severity:* Current depressive episode is moderate to severe, documented by a validated severity scale score (PHQ-9 ≥10 or equivalent validated instrument such as HAM-D, MADRS).

3. *Treatment failure or intolerance:* Documentation of at least ONE of the following in the current depressive episode: a. Failure of ≥1 adequate antidepressant medication trial (adequate = therapeutic dose per FDA label, ≥4–6 weeks duration) in the current episode b. Clinically significant adverse effects precluding adequate antidepressant trial c. Medical contraindication to antidepressant medications d. Patient preference for non-pharmacological treatment after a documented informed discussion of treatment options (payer-specific — coverage subject to benefit plan terms)

4. *Provider qualification:* Treatment is supervised by a psychiatrist or MD/DO with training in TMS administration.

5. *Screening:* Patient evaluated for absolute contraindications prior to initiation: - Ferromagnetic implants in or near the head (aneurysm clips, cochlear implants, implanted electrodes) - Active seizure disorder or history of seizures (except isolated febrile seizures in infancy) - Skull defects with missing bone at the stimulation site

6. *Informed consent:* Documented written informed consent.

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

4C.2 TMS — Additional FDA-Cleared Indications (Adults)

Obsessive-Compulsive Disorder (OCD) — BrainsWay Deep TMS System Only:

1. Confirmed OCD diagnosis (ICD-10: F42.2, F42.8) with moderate-to-severe symptom severity (Y-BOCS score ≥20 or equivalent).

2. Inadequate response to ≥1 adequate SSRI trial (appropriate dose, ≥8–12 weeks duration) in the current episode.

3. Treatment is provided using the BrainsWay Deep TMS system with H7 coil (the only FDA-cleared TMS device for OCD as of this policy's effective date).

4. Informed consent documented; OCD-specific TMS protocol followed.

Smoking Cessation — BrainsWay Deep TMS System Only:

1. Active tobacco use disorder with documented desire to quit.

2. Treatment is adjunctive to evidence-based cessation counseling.

3. BrainsWay system with FDA-cleared smoking cessation protocol utilized.

4C.3 TMS — Evidence-Based Indications with APA Consensus Support

The following uses have APA and/or NNDC (National Network of Depression Centers) consensus support and may be considered for coverage subject to benefit plan terms and case-by-case review:

1. *Adjunctive TMS for MDD with anxious distress:* MDD with significant anxious features meeting MDD criteria above; APA/NNDC consensus: rTMS is appropriate for MDD patients with significant comorbid anxiety.

2. *Continuation/maintenance TMS:* For members who achieved clinically meaningful response to an acute TMS course and are experiencing depressive recurrence: a. Documentation of prior positive acute TMS response b. Inadequate response to or relapse on maintenance pharmacotherapy c. Continuation/maintenance protocol must be clinically justified

---

4C.4 TMS Code-Specific Criteria

`90867` — *Initial TMS Treatment Session:*

1. All 4C.1 or 4C.2 criteria met.
2. 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. FDA-cleared indication criteria remain active.
2. Ongoing documentation of treatment response and tolerability.
3. Maximum 36 sessions for standard acute course without documented clinical justification for extension.

90869 — *Subsequent Motor Threshold Re-Determination:*

1. Clinical justification for re-determination documented (e.g., significant change in patient condition, extended gap in treatment, equipment change, medication change affecting seizure threshold).
2. Criteria for ongoing treatment course remain met.

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

4D.1 ECT — Major Depressive Disorder (Adults 18+)

All of the following criteria must be met:

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

2. *Severity and indication:* At least ONE of the following must be present: a. Treatment-resistant depression (TRD): Failure of ≥2 adequate antidepressant medication trials with different pharmacological mechanisms in the current episode (adequate = therapeutic dose, ≥4–6 weeks duration) b. Psychotic features: MDD with psychotic features — ECT is preferred over antidepressant monotherapy for this presentation (APA guidelines) c. Life-threatening severity: Active suicidality with plan and intent, inability to maintain adequate nutrition or hydration, severe psychomotor agitation, or acute medical deterioration due to depression d. Rapid clinical response required: Acute suicidality with imminent plan, severe medical instability from psychiatric condition e. Medication intolerance: Documented intolerance to or contraindication of antidepressant medications preventing adequate pharmacotherapy trials f. Pregnancy: ECT is the preferred treatment for severe depression in pregnancy when rapid response is required and medication risks are not acceptable; documented OB/perinatal psychiatry consultation g. Advanced age with poor medication tolerance: Elderly patients with cardiac, hepatic, or renal comorbidities precluding adequate pharmacotherapy

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

4. *Informed consent:* Written informed consent documented by the member or legally authorized surrogate.

5. *Psychiatrist supervision:* ECT is ordered and supervised by a psychiatrist with training in ECT. Anesthesia administered by anesthesiologist or CRNA.

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

4D.2 ECT — Bipolar Disorder (Adults 18+)

Authorization criteria for ECT in bipolar disorder require:

1. *Diagnosis:* Confirmed bipolar disorder (ICD-10: F31.1, F31.2, F31.4, F31.5, F31.6) with an acute severe episode.

2. *Indication:* At least ONE of the following: a. Severe bipolar depression: Failure of ≥2 adequate trials (lithium, quetiapine, lurasidone, or other guideline-concordant agents) in the current depressive episode; OR life-threatening severity b. Severe acute mania: Refractory to combination of mood stabilizer(s) and antipsychotic(s); or requiring rapid response for safety c. Mixed features with high suicidality where rapid response is required d. Bipolar disorder with catatonic features

3. Medical clearance, informed consent, and psychiatrist supervision requirements are identical to Section 4D.1 items 3–5.

4D.3 ECT — Catatonia (Adults 18+)

Authorization criteria for ECT in catatonia require:

1. *Diagnosis:* Catatonic syndrome (ICD-10: F20.2 — catatonic schizophrenia; F44.2 — dissociative stupor; catatonic specifier for applicable F30–F33 codes; or organic catatonia) of any etiology.

2. *Indication:* At least ONE of the following: a. Catatonia that has failed or insufficiently responded to an adequate benzodiazepine trial (lorazepam challenge positive, with failure to sustain response) b. Malignant catatonia: Life-threatening presentation with hyperthermia, autonomic instability, rhabdomyolysis — ECT is first-line treatment, potentially concurrent with benzodiazepines c. Catatonia in the context of neuroleptic malignant syndrome requiring urgent intervention

3. ECT for catatonia is an FDA Class II indication; response rates of 80–100% in modern literature.

4. Medical clearance, informed consent, and psychiatrist supervision requirements are identical to Section 4D.1 items 3–5.

4D.4 ECT — Schizophrenia/Schizoaffective Disorder (Adults 18+)

1. *Diagnosis:* Schizophrenia (F20.x) or schizoaffective disorder (F25.x).

2. *Indication:* At least ONE of the following: a. Treatment-refractory schizophrenia: Failure of ≥2 adequate antipsychotic trials (including at least one trial of clozapine unless clinically contraindicated) b. Augmentation of clozapine in patients with insufficient response to clozapine alone c. Severe acute exacerbation requiring rapid global clinical improvement where antipsychotics have not produced adequate response within a reasonable timeframe

3. Medical clearance, informed consent, and psychiatrist supervision requirements are identical to Section 4D.1 items 3–5.

4D.5 Continuation/Maintenance ECT (C/MECT — Adults 18+)

Authorization for continuation/maintenance ECT requires:

1. Member achieved clinically meaningful response during an acute ECT course.

2. At least ONE of the following: a. History of relapse or significant clinical deterioration following discontinuation of ECT in prior episodes, with inability to maintain remission on pharmacotherapy alone b. Inability to tolerate adequate maintenance pharmacotherapy c. Patient preference for continued ECT as maintenance in documented discussion with psychiatrist with documented clinical rationale

3. *Continuation ECT schedule (typical):* 4 treatments over the first month post-acute, then tapering schedule. *Maintenance ECT schedule (typical):* Weekly to monthly treatments on individualized schedule, based on sustained clinical response.

4. Ongoing psychiatric assessment at each treatment, with documentation of continued clinical response or medical necessity.

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

4E.1 Inpatient Psychiatric Admission Criteria (18 and Over)

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 safely or effectively 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 psychiatric evaluation, medication management, nursing/medical intervention, and multidisciplinary care.

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

4. A psychiatrist or MD/DO with psychiatric training performs an initial evaluation within 24 hours of admission documenting: a. Chief complaint and description of acute illness b. Evidence of failure at lower level of care or reason lower level is unsafe c. Mental status

examination d. Physical examination e. Past psychiatric and medical history; substance use history f. Formulation including reasonable expectation of improvement from inpatient treatment

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

6. An individualized treatment plan addressing biological, psychological, 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 within 72 hours of admission.

9. Severe self-mutilation (actual or threatened) within 72 hours of admission posing significant, immediate threat to life or limb.

10. Chronic self-destructive behavior representing a significant, immediate threat in the acute context.

11. Homicidal ideation with plan, intent, and means.

12. Command auditory hallucinations directing harm to self or others.

13. Acute psychotic episode (first-break or relapse) with grossly disorganized behavior, inability to maintain safety, or inability to maintain self-care.

14. Severe agitation or dangerous aggression toward others requiring 24-hour physical containment.

15. Psychiatric disorder causing inability to maintain adequate nutrition or self-care AND community supports are unavailable or insufficient.

16. Acute delirium or cognitive impairment from psychiatric disorder that endangers the member's welfare.

17. Need for initiation of a psychotropic medication with significant adverse-effect profile requiring monitored inpatient setting (e.g., clozapine initiation, lithium initiation with complex medical comorbidity).

18. Severe adverse effects from psychotropic medications requiring inpatient medical management (e.g., lithium toxicity, NMS, serotonin syndrome requiring active psychiatric and medical intervention).

19. LOCUS score consistent with Level 6 (Medically Managed Residential Services or equivalent inpatient) where LOCUS has been performed.

4E.2 Inpatient SUD — ASAM Level 4.0 (18 and Over)

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 medically managed inpatient setting (e.g., alcohol withdrawal delirium risk — CIWA score ≥10 with escalating risk; opioid withdrawal with severe medical complications; sedative-hypnotic withdrawal with seizure risk) b. *Dimension 2:* Biomedical conditions requiring concurrent acute medical management (e.g., Wernicke's encephalopathy, hepatic failure, severe malnutrition) c. *Dimension 3:* Co-occurring emotional/behavioral conditions requiring inpatient psychiatric management d. *Dimension 4:* Readiness to change, and related risk factors e. *Dimension 5:* Relapse or continued use potential f. *Dimension 6:* Person-centered considerations including SDOH barriers, recovery environment, patient preferences

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

4. ASAM Level 4.0 services are provided in an acute care hospital with appropriate medical staffing.

ASAM Level 3.7 (Medically Managed Residential — 18 and Over):

Authorization criteria for Level 3.7:

1. Severe SUD with complex biomedical or psychiatric complications that can be managed in a 24-hour residential setting without full acute hospital capabilities.

2. ASAM 6-dimension assessment supports residential-level (Level 3.7) management rather than acute inpatient (Level 4.0).

3. 24-hour medical and nursing management is required but acute hospital level medical capabilities are not.

4E.3 Continued Inpatient Stay Criteria (18 and Over)

Each continued stay review requires documentation of ALL of the following:

1. Ongoing active psychiatric or SUD symptoms require 24-hour medical supervision; lower level of care remains clinically unsafe.

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

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

4. Discharge planning is actively ongoing with an identified step-down level of care and target discharge timeline.

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

4F. 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 4E.1 or 4E.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. *Psychotherapy codes (*90832, 90834, 90836, 90838*):* Session with the member; documentation includes therapeutic modality, goals, and clinical content. 90836 and 90838 are add-on codes for psychotherapy performed concurrent with an evaluation and management service.

4. *Family therapy (*90846, 90847*):* Clinically indicated; 90846 (without patient) and 90847 (with patient) are not billed on same date for same provider-patient relationship.

5. *Group therapy (*90849, 90853*):* Therapeutically appropriate; group notes document member participation.

6. 90785 *(interactive complexity):* Add-on only; used when significant communication difficulties are present (e.g., mandated reporting obligations, legal guardian involvement, active psychosis creating complexity in communication).

7. S9484 *(crisis intervention):* Documented acute psychiatric crisis requiring urgent intervention distinct from scheduled therapy.

8. H0010, H0011 *(detoxification):* Medically supervised residential detoxification; SUD diagnosis; withdrawal management in residential setting.

9. 99232 *(subsequent hospital care):* Physician/QHP renders inpatient E&M service; moderate complexity decision-making documented.

10. G0407, G2074 *(collaborative care):* Care management activities performed as part of a collaborative care model per CMS requirements; Behavioral Health Care Manager has appropriate qualifications; treating physician (or authorized designee) is engaged in collaborative care team.

11. H0038 *(peer services):* Peer support specialist provides structured peer support as part of the treatment plan; service is documented in treatment plan and delivered by certified peer specialist.

4G. 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 or SUD diagnosis as the primary focus of treatment.

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

3. Treatment addresses active psychiatric or SUD symptoms causing functional impairment.

4. Services are not duplicative of services provided simultaneously at a more intensive level.

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

4H.1 Standard Outpatient Behavioral Health

For H0004 *(behavioral health counseling/therapy) and* H0005 *(group counseling, SUD):*

1. The member has a current, active DSM-5-TR BH or SUD diagnosis as primary focus of service.

2. Treatment is medically necessary to address active psychiatric or SUD symptoms causing functional impairment.

3. An evidence-based treatment approach appropriate to the diagnosis is utilized. APA-endorsed adult evidence-based treatments include: - MDD (mild-moderate): CBT, Interpersonal Therapy (IPT), behavioral activation; SSRIs/SNRIs - MDD (severe): CBT + pharmacotherapy combined; TMS if treatment-resistant - Bipolar disorder: Evidence-based psychotherapy (CBT, IPSRT — Interpersonal and Social Rhythm Therapy) adjunctive to mood stabilizer - PTSD: Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), EMDR; SSRIs/SNRIs - OCD: Exposure and Response Prevention (ERP); SSRI (combined for moderate-severe) - Schizophrenia: Antipsychotics; CBT for psychosis; family psychoeducation; social skills training - SUD (outpatient): CBT, Motivational Interviewing, 12-step facilitation; Medication-Assisted Treatment (MAT): buprenorphine/naloxone, naltrexone, or methadone for OUD; naltrexone, acamprosate for AUD - Anxiety disorders: CBT (first-line); SSRIs/SNRIs; exposure-based therapy - Borderline Personality Disorder: Dialectical Behavior Therapy (DBT)

4. An individualized treatment plan with measurable goals is in place and updated at least every 90 days or when clinically indicated.

5. Progress toward treatment goals is documented in the clinical record.

For 90792 *in the outpatient setting:* All criteria in Section 4B.1 (90792) apply. MD/DO only.

4H.2 Intensive Outpatient Program (IOP) — H0015 and S9480

All of the following must be met:

1. Member has a current DSM-5-TR BH or SUD diagnosis with moderate symptoms and functional impairment.

2. Clinical assessment indicates the appropriate level of care: - MH IOP: LOCUS score consistent with Level 3–4 (high-intensity community-based or medically monitored non-residential services) - SUD IOP: ASAM 6-Dimension assessment supporting Level 2.1 (Intensive Outpatient)

3. Member can be safely managed outside of a 24-hour setting with structured outpatient support.

4. IOP program provides: - `H0015`: Minimum 3 hours/day, minimum 3 days/week of structured treatment - `S9480`: Per diem intensive outpatient psychiatric services

5. Programming includes individual therapy, group therapy, psychiatric/medication management, and psychoeducation as clinically appropriate.

6. At least ONE of the following clinical justifications: a. Step-down from inpatient or PHP level of care b. Step-up from standard outpatient due to inadequate treatment response or clinical deterioration c. Moderate psychiatric or SUD symptoms requiring more than weekly outpatient contact to maintain safety and stability

---

4H.3 Outpatient SUD Services (`H0012`, `H0013`, `H0014`, `H0016`)

1. `H0012` *and* `H0013` *(SUD Education):* Active SUD diagnosis or documented substance use history; education is a component of a treatment plan.

2. `H0014` *(Ambulatory Detoxification):* Active SUD with withdrawal potential; ASAM Dimension 1 assessment supports ambulatory management (mild-to-moderate withdrawal not requiring inpatient or residential medical management); physician supervision of detoxification protocol.

3. `H0016` *(Medical/Somatic — SUD):* Physician or other medical provider renders medically necessary ambulatory intervention for SUD-related medical condition; clinically distinct from behavioral counseling services.

4I. PARTIAL HOSPITALIZATION (`S0201`)

4I.1 PHP Admission Criteria (18 and Over)

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

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

2. PHP provides a minimum of 20 hours per week of structured active psychiatric or SUD treatment.

3. Member is NOT at imminent risk of harm to self or others requiring 24-hour containment. If imminent risk is present, inpatient is required.

4. Member has an adequate support system (home, community, or structured housing) providing safety and support outside of PHP hours.

5. Admission and plan of care are certified by a psychiatrist or MD/DO with appropriate training.

6. Treatment plan is individualized and addresses the member's clinical presentation with specific measurable goals.

7. LOCUS score is consistent with Level 4–5 (Intensive Community-Based or Medically Monitored Non-Residential Services) 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 (standard PHP use case).

9. Acute or significant decompensation of a DSM-5-TR psychiatric or SUD disorder severely interfering with multiple areas of daily functioning (work, social, self-care), where PHP is necessary to prevent inpatient admission.

10. Moderate psychiatric symptoms requiring daily clinical monitoring where IOP is clinically insufficient.

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

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

13. SUD with moderate risk in ≥1 ASAM dimension where ASAM Level 2.5 is the appropriate level (≥20 hours/week structure without 24-hour nursing management).

4I.2 Continued PHP Authorization (18 and Over)

Each continued stay authorization requires:

1. Active psychiatric or SUD symptoms remain at a level requiring PHP intensity (≥20 hours/week).

2. Member is attending scheduled PHP sessions; absences are documented with clinical explanation.

3. Discharge to IOP or outpatient has not yet become clinically safe.

4. Active treatment is occurring with documented progress or explained deviation from expected progress.

5. Step-down plan is in place with target date and identified next level of care.

SECTION 5: MEDICAL NECESSITY CRITERIA — DOES NOT MEET CRITERIA

SECTION 5 [Z]: ABA THERAPY — DOES NOT MEET CRITERIA (ADULTS 18 AND OVER)

This section specifies all ABA denial bases for adult members and supersedes the original ABA "Does Not Meet" criteria from Version 1.0 of this policy.

5Z-A: Diagnostic Exclusions

5Z-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.

5Z-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.

5Z-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
- Anxiety disorders as a sole diagnosis, without co-occurring ASD
- Personality 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, intellectual disability) may also be present alongside ASD without disqualifying coverage.

5Z-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 adult members with exclusively F84.2 or F84.3 diagnoses do not qualify under this policy.

5Z-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.

5Z-A.6 ABA services for an adult 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 4Z-J.2.)

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

5Z-B: Provider Qualification Exclusions

5Z-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

5Z-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.

5Z-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.

5Z-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 adult member present are not billable under `97155`.

5Z-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.

5Z-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.

5Z-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.

5Z-C: Service-Type Exclusions

5Z-C.1 Custodial care, respite care, or companion services: 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.

5Z-C.2 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.

5Z-C.3 Telehealth delivery of codes that require in-person delivery: ABA services billed via telehealth under codes that require in-person delivery (`97153`, `0362T`, `0373T`) do not meet criteria. Telehealth delivery of these codes is not an acceptable substitute for in-person services.

5Z-C.4 Group therapy 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.

5Z-C.5 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
- *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
- *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* — DIR/Floortime 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
- *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
- *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 is

distinct and may be covered

- *Home modifications and assistive devices billed as ABA* — physical modifications or assistive devices are not billable as ABA services
- *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

5Z-C.6 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 member's services

5Z-C.7 `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.

5Z-C.8 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.

5Z-C.9 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`.

5Z-C.10 Failure to meet support person participation threshold after documented accommodation: Where, after good-faith effort and documented accommodation, the support person participation threshold (≥80% of scheduled sessions) continues not to be met without clinically acceptable justification, the support person training component of the authorization is subject to reduction. Failure of support person involvement alone is NOT grounds for termination of the adult member's entire ABA program. See Section 4Z-G.4.

5Z-C.11 Lack of measurable progress over 6 months after appropriate plan revisions: Where individualized review (per Section 4Z-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.

5Z-C.12 Authorization of hours beyond adult caps without exceptional clinical justification: Requests for weekly hours exceeding the limits in Section 4Z-B-1 without documented extraordinary clinical justification and heightened clinical review do not meet standard criteria.

5Z-D: Documentation Exclusions

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

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

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

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

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

5Z-D.6 Treatment plan that is a template or generic document not individualized to the adult member's specific behavioral profile, life circumstances, and adult-functional goals.

5Z-D.7 Support person participation documentation is absent at reauthorization, where support person training is included in the treatment plan and no clinical rationale for non-participation is provided.

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

5Z-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.

5Z-D.10 Daily session notes that do not include all required elements: date, start time, stop time, total session duration, setting, provider name/credentials/BACB certification number, goals targeted, data collected on each goal, documentation of member/support person involvement, behavior incidents in ABC format (if any), and clinical decisions made.

5Z-E: MHPAEA Compliance — Limitations That Are NOT Applied to Adult ABA

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

5Z-E.1 Hard age cutoffs: Categorical exclusions of ABA coverage solely based on the member's age, without documentation that comparable age limits apply to medical/surgical benefits under the same plan. CHP does not apply categorical denial of adult ABA coverage based on age alone.

5Z-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 (TX: $36,000/year; FL: $36,000/year and $200,000 lifetime; GA: $35,000/year), CHP evaluates MHPAEA compliance before applying these caps to fully insured plans.

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

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

5Z-E.5 Categorical setting exclusions: Categorical exclusion of home-based, community-based, or workplace-based ABA for adults solely on the basis of the setting, without specific analysis of whether the goals addressed in that setting are duplicative of services another entity is obligated to provide.

5Z-E.6 Mandatory support person participation as an absolute condition of authorization without individualized review: Terminating the adult member's entire ABA authorization solely based on support person non-participation without individualized assessment of the clinical impact, without exploring accommodations, and without acknowledging that some adults with ASD may not have available or appropriate support persons in their lives.

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

5Z-F: Concurrent Service Rules (Adults 18 and Over)

5Z-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 4Z-L.3.

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

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

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

5Z-F.5 Vocational rehabilitation services: Insurance-funded ABA may be covered concurrently with vocational rehabilitation services when the ABA goals address distinct behavioral targets complementary to (not duplicative of) the vocational rehabilitation program. Coordination documentation is required quarterly.

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

5Z-F.7 Cannot bill `0373T` and `97155` in the same session.

5Z-F.8 Simultaneous billing during overlapping time for concurrent ABA and SLP/OT/PT is not permitted. If an adult member receives ABA and SLP in overlapping time, only one service may

be billed for that time period.

5Z-G: Documentation Standards — Daily Session Notes (Adults 18 and Over)

Every ABA session (97153, 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, workplace, adult day program)
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. *Support person/caregiver involvement* (if applicable): whether support person was present, activities conducted with support person, support person participation in session; whether the member consented to support person involvement in that 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 (Every 6 Months): 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, with adult-functional relevance documented
3. *Hour utilization versus authorized hours* for the prior period, including an explanation if there is significant under-utilization
4. *Support person training completion* — number of sessions scheduled vs. attended; support person competency data
5. *Updated Vineland-3 and criterion-referenced assessment results* (AFLS, VB-MAPP, or ABLLS-R)
6. *Plan for transition and discharge* with updated projected timeline and discharge criteria tied to adult functional independence

---

5A. BH Evaluations — Does Not Meet Criteria

1. 90792 is billed by a non-physician provider.
2. 90791 and 90792 billed by same provider on same date of service.
3. A psychiatric diagnostic evaluation billed for a routine therapy session or medication management check.

4. Evaluation conducted solely for administrative, legal, vocational, forensic, or disability determination purposes without concurrent clinical treatment need.

5. Repeat diagnostic evaluation within 12 months without documented clinical justification.

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

7. Evaluation codes (`96130`–`96133`) billed without corresponding test administration codes.

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

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

10. Testing performed more than once per year without documented medical necessity.

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

5B. TMS — Does Not Meet Criteria

1. Primary diagnosis is not an FDA-cleared TMS indication (bipolar depression, PTSD, schizophrenia without FDA clearance are not covered for routine TMS in adults; see Sections 4C.1–4C.3 for covered indications).

2. Current depressive episode severity is mild (PHQ-9 <10) without documented significant functional impairment.

3. No documented failure of or clinically documented intolerance to at least one adequate antidepressant trial in the current depressive episode (absent documented patient preference after informed discussion, per benefit plan terms).

4. Ferromagnetic implants near the head are present (absolute contraindication).

5. Active seizure disorder (absolute contraindication — except isolated febrile seizures in infancy or ECT-induced seizures with anesthesia present).

6. Active psychotic symptoms without adequate antipsychotic treatment — TMS is not appropriate when active psychosis is present without adequate antipsychotic coverage; ECT should be considered.

7. OCD indication: TMS device used is not the BrainsWay system with H7 coil (the only FDA-cleared OCD TMS device).

8. Depression is entirely attributable to active, untreated substance use without concurrent SUD treatment.

9. Continuation/maintenance TMS requested without documentation of prior positive acute TMS response.

10. Bipolar depression, PTSD, schizophrenia, or other non-FDA-cleared indications — not authorized for routine coverage absent updated FDA clearance.

5C. ECT — Does Not Meet Criteria

1. Elevated intracranial pressure with mass effect — the only absolute contraindication to ECT.
2. Mild-to-moderate depression that has not failed at least two adequate antidepressant trials with different pharmacological mechanisms (unless life-threatening urgency or pregnancy indication exists).
3. Primary SUD without co-occurring psychiatric condition meeting ECT criteria.
4. Chronic pain as sole indication.
5. Cognitive enhancement as sole indication.
6. Member lacks capacity to consent and no appropriate legally authorized surrogate is available or identifiable.
7. Addictive disorders (methamphetamine dependence, alcohol use disorder, etc.) without co-occurring psychiatric diagnosis that independently meets ECT criteria.

Relative Contraindications Requiring Specialist Clearance (Not Automatic Denials): Recent myocardial infarction, intracranial lesion without mass effect, pheochromocytoma, cardiac arrhythmias, high anesthesia risk. These require anesthesia/medical specialist clearance but do not constitute automatic ECT denial when psychiatric indication is 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.
2. Primary clinical problem is a general medical condition without concurrent acute major psychiatric episode.
3. Admission for custodial, social, respite, or housing placement purposes rather than active psychiatric treatment.
4. Court-ordered admission that does not independently meet medical necessity criteria.
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. Primary SUD without co-occurring active psychiatric condition requiring inpatient psychiatric care (SUD detoxification is separately addressed under ASAM criteria).
8. Social, relational, or situational stressors without concurrent acute psychiatric decompensation meeting intensity criteria.
9. *Continued stay is not medically necessary when:* a. Member no longer demonstrates imminent risk to self or others b. Member is no longer grossly impaired, disorganized, or acutely psychotic c. Member can be safely managed at PHP or IOP level d. Inpatient treatment goals have been met e. Member is persistently refusing active treatment without new clinical indications f. Inpatient admission is being maintained for placement or disposition delays unrelated to ongoing medical necessity

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 rendered primarily for social, educational, vocational, or recreational purposes without a diagnosable clinical BH condition.
3. Treatment modality is experimental, investigational, or not evidence-based.
4. Services rendered by unlicensed provider without appropriate licensed supervision.
5. Duplicate billing for the same service on the same date by same provider.
6. Sessions primarily for life coaching, personal development, or general stress management without a diagnosable BH condition.
7. IOP (`H0015`, `S9480`): Symptoms stable and manageable with standard outpatient therapy.
8. IOP: Member requires higher level (PHP or inpatient) than IOP can safely provide.

5F. Partial Hospitalization — Does Not Meet Criteria

1. Member requires 24-hour observation or containment → inpatient is required.
2. Symptoms stable and manageable with IOP or standard outpatient care.
3. PHP does not provide a minimum of 20 hours/week of active treatment.
4. Multiple unexcused absences from scheduled PHP sessions without documented clinical justification.
5. Care is primarily social, custodial, recreational, or respite-based.
6. PHP used for chronic management of stable psychiatric condition without acute decompensation.
7. Member is cognitively unable to participate in active treatment and alternative lower-level care is clinically appropriate.
8. Member is at imminent risk requiring hourly monitoring — inpatient is required, PHP is insufficient.

SECTION 6: CLINICAL BACKGROUND

6A. ABA Therapy in Adults — Clinical Background

Applied Behavior Analysis (ABA) is a scientific discipline based on the principles of learning theory and behavior analysis, applied to increase adaptive behaviors and decrease maladaptive behaviors using systematic, data-driven methods. BACB guidelines confirm that ABA treatment for autism spectrum disorder and developmental disabilities is effective across the lifespan, including for adult patients with functional deficits.

Adult ABA typically targets specific behavioral goals related to vocational functioning, community integration, independent living, employment readiness, health and safety behaviors,

communication (including AAC implementation), and reduction of maladaptive behaviors that interfere with adult community participation. The clinical evidence base includes well-established foundational studies (Lovaas 1987; McEachin, Smith & Lovaas 1993; Reichow et al. Cochrane Review 2018) and a growing body of evidence supporting ABA across the lifespan. The National Academies of Sciences, Engineering, and Medicine (2025) reviewed the ABA evidence base and concluded that there is substantial evidence of efficacy and effectiveness meeting the criterion of reliable evidence of efficacy. For adults specifically, the evidence base is described by BACB, CASP (Version 3.0, 2024), and multiple professional bodies as supporting ongoing coverage for skill maintenance, skill development in adult-functional domains, and reduction of challenging behaviors.

Authorization criteria for adults focus on documented functional impairment, individualized treatment targets aligned with adult life domains, and evidence of clinical benefit from the ABA approach. Adult ABA authorization is not categorically excluded on the basis of age alone. MHPAEA requires that coverage criteria for ABA not be more restrictive than analogous medical/surgical benefit criteria in the same benefit classification.

6B. BH Evaluations — Adults

Psychiatric diagnostic evaluations and psychological/neuropsychological testing are foundational to accurate diagnosis, treatment planning, and outcome monitoring in adult behavioral health. Neuropsychological testing in adults is particularly important for: dementia and mild cognitive impairment workups, TBI rehabilitation planning, pre-ECT cognitive baselines, and assessment of cognitive effects of psychiatric illness or substance use. The APA Services Psychological and Neuropsychological Testing Billing and Coding Guide (2024) provides the coding framework for adult testing services.

6C. TMS in Adults

TMS was FDA-cleared for adult MDD in 2008 (NeuroStar). An evidence base of over 118 published studies supports rTMS efficacy for MDD. An APA/NNDC consensus statement published in the Journal of Clinical Psychiatry (McClintock et al., PMC5846193) provides clinical consensus recommendations for rTMS use in adult MDD, including confirmation that rTMS is appropriate for patients with comorbid anxiety. The FDA-cleared BrainsWay Deep TMS system received additional clearances for OCD (2018) and smoking cessation (2020). CMS Medicare LCD L34998 establishes national coverage criteria for adult TMS for MDD.

6D. ECT in Adults

ECT is the most effective available treatment for severe, treatment-resistant depression, severe mania, and malignant catatonia, with response rates of 70–90% across indication categories. The APA Task Force on ECT supports ECT as first-line or second-line treatment for TRD, psychotic depression, severe mania, and catatonia. ECT was reclassified from FDA Class III to Class II for specific indications in 2018. The only absolute contraindication is elevated intracranial pressure with mass effect; all other potential concerns are relative and require risk-benefit analysis, not automatic denial.

6E. Inpatient Psychiatric Care (Adults)

CMS LCD L34570 defines coverage criteria for inpatient psychiatric hospitalization under Medicare. Commercial payer criteria must not be more restrictive than these CMS criteria under MHPAEA. The LOCUS provides a validated framework for adult level-of-care placement. ASAM Criteria (4th Edition, 2023) provides the clinical framework for SUD level-of-care placement across all settings, from outpatient to medically managed inpatient.

6F. TMS and ECT Facility Requirements

TMS is typically provided in outpatient settings under psychiatrist supervision. ECT requires an anesthesiologist or CRNA and is typically performed in a hospital outpatient or inpatient setting with full resuscitation equipment available. The treating psychiatrist must have documented training in ECT administration.

6G. PHP and IOP

Partial hospitalization (minimum 20 hours/week) and intensive outpatient programs (minimum 9 hours/week for SUD IOP under ASAM; minimum 3 hours/day × 3 days/week for `H0015`) provide structured treatment at lower intensity than inpatient care. CMS LCD L33626 establishes clinical standards for psychiatric PHP. ASAM Levels 2.1 (IOP) and 2.5 (high-intensity outpatient/PHP) provide the SUD clinical framework for these levels.

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
- Coverage criteria, PA requirements, and benefit limitations for BH/SUD services shall not be more restrictive than those applied to analogous medical/surgical benefits within the same classification.
- PA requirements for ABA, PHP, IOP, inpatient psychiatric, and ECT/TMS must be compared to PA requirements for analogous medical/surgical services. Differences must be clinically justified through documented NQTL comparative analysis.
- Medical necessity criteria in this policy must be grounded in the same quality and type of evidence used for analogous medical/surgical benefit criteria.
- The 2013 MHPAEA implementing regulations remain fully in force. The 2024 MHPAEA Final Rule is under non-enforcement review pending litigation as of March 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 is one of ten ACA-required EHBs for fully insured individual and small group plans.

- EHBs apply to Fully Insured and Level Funded products; ASO (self-funded ERISA) plans are not subject to EHB mandates.

ASO Plans: State insurance mandates including autism mandates generally do NOT apply to self-funded ERISA plans. MHPAEA applies to self-funded ERISA plans with 51+ employees.

SECTION 7Z: ABA STATE MANDATE ANALYSIS — ADULT APPLICABILITY (18 AND OVER)

This section provides detailed analysis of state ABA mandates in all seven CHP operating states, with particular emphasis on adult applicability and MHPAEA implications. It supersedes the ABA state regulatory notes from Version 1.0 of this policy.

APPLICABILITY NOTICE

The state mandates described in this section apply ONLY to fully insured plans subject to state insurance regulation. Self-funded ERISA plans (ASO products) and level-funded plans operating as self-funded are generally exempt from state insurance mandates under ERISA preemption (29 U.S.C. § 1144).

Federal MHPAEA applies to all applicable plan types (fully insured, self-funded, level funded). Where state mandate provisions may conflict with MHPAEA parity requirements, federal MHPAEA takes precedence for plans subject to both. Curative Health Plan evaluates MHPAEA compliance before applying any state mandate limitation that could constitute a QTL or NQTL more restrictive than comparable medical/surgical benefits.

ASO/Self-Funded ERISA Plans: For ASO and self-funded ERISA plans, state mandates do not apply. However, the hour caps and supervision requirements as set forth in Sections 4Z-B-1, 4Z-C, and 4Z-E of this policy DO apply and are used as the clinical framework for medical necessity review.

Fully Insured Plans — More Favorable Rule: For fully insured plans, CHP applies the more favorable of the state mandate and the criteria in this policy. Where a state mandate provides more generous coverage (e.g., Maryland's no-dollar-cap provision, Indiana's no-age-limit provision), the state mandate governs for that provision.

7Z-A: Texas — ABA State Mandate (Adult Applicability)

Statute: Texas Insurance Code § 1355.015 (enacted by 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* — the Texas mandate has no upper age limit

Provision	Statutory Requirement
Diagnosis-Before-Age-10 Requirement	The member must have been *diagnosed with ASD before their 10th birthday* to qualify for mandate coverage. Adults diagnosed with ASD for the first time in adulthood (after their 10th birthday) do not qualify for Texas mandate coverage.
Annual Dollar Cap	No cap for individuals diagnosed before age 10 who are *under age 10*; *$36,000/year* for covered individuals *age 10 and older* (diagnosed before age 10)
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
ASO Plans	Mandate does NOT apply; MHPAEA applies; criteria of this policy apply

Adult Applicability Analysis (Texas): For adult members (18+) on fully insured Texas plans:

- If the member was diagnosed with ASD *before age 10*, the Texas mandate provides coverage for ABA services with no upper age cap, subject to the $36,000/year annual cap for members currently age 10 or older.
- If the member was diagnosed with ASD *at age 10 or later* (including first-time adult diagnosis), the Texas mandate does not apply; coverage is governed by MHPAEA parity analysis.

MHPAEA Parity Analysis (Texas): The $36,000/year annual dollar cap for members age 10+ is a potential Quantitative Treatment Limitation (QTL) under MHPAEA. The diagnosis-before-age-10 eligibility requirement is a potential Non-Quantitative Treatment Limitation (NQTL). *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 subject to MHPAEA.* Members whose adult ABA is medically necessary and whose plans are subject to MHPAEA may receive coverage beyond the Texas statutory floor if comparable medical/surgical benefits lack equivalent dollar caps or eligibility restrictions.

> Legislative Note: Proposed legislation to remove the $36,000/year cap and the diagnosis-before-age-10 requirement has been introduced in recent Texas legislative sessions. As of the last reviewed date of this policy (April 27, 2026), such legislation has not been enacted. Verify current statutory requirements with CHP's legal and compliance department.

Other Texas Regulatory Notes:

- *ECT Requirements:* Texas requires additional physician attestation for ECT under Texas Health & Safety Code. Treating psychiatrist must document compliance with Texas consent and attestation requirements. Facilities providing ECT must hold appropriate Texas state certifications.
- *Prior Authorization Reform (HB 3812, 2025):* UR for TX fully insured/level-funded must be by a Texas-licensed physician. Same-specialty review required for medical necessity appeals. Gold Card exemption: providers with ≥90% approval rate over 12 months are

exempt from PA for that service.

• *Step Therapy Reform:* Step therapy override process required; override must be granted when clinically justified.

7Z-B: Florida — ABA State Mandate (Adult Applicability)

Statute: Florida Statutes § 627.6686 (group health insurance plans); § 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, individually underwritten 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*
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)
Physician Requirement	Coverage is limited to treatment prescribed by the insured's treating physician (physician prescription is required under this mandate)
ASO Plans	Mandate does NOT apply; MHPAEA applies; criteria of this policy apply

Adult Applicability Analysis (Florida): For adult members (18+) on fully insured Florida group plans:

• The Florida mandate applies to members who are 18 or older AND still enrolled in high school. Once the member leaves high school, the Florida mandate no longer provides statutory coverage.

• Adult members (18+) not enrolled in high school are NOT covered under the Florida state mandate; however, MHPAEA parity analysis may require coverage of medically necessary ABA if the plan covers analogous medical/surgical benefits without equivalent age or eligibility restrictions.

• The $36,000/year and $200,000 lifetime caps apply to any members who do qualify under the mandate.

MHPAEA Parity Analysis (Florida): The $36,000/year annual cap, the $200,000 lifetime cap, and the diagnosis-before-age-8 eligibility requirement, and the age-18/still-in-high-school upper limit 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.

Florida External Review: Florida operates under the HHS-Administered Federal External Review Process alongside state process. Standard external review: 45 days; expedited: 72 hours.

7Z-C: Georgia — Ava's Law (Adult Applicability)

Statute: 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 (Article 1 of Chapter 18 of Title 45)
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))
Provider Requirements	ABA must be provided by a BCBA or under BCBA supervision; 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
ASO Plans	Mandate does NOT apply; MHPAEA applies; criteria of this policy apply

Adult Applicability Analysis (Georgia): For adult members (18+) on fully insured Georgia plans:

- Members *ages 18, 19, and 20* (under 21): The Georgia mandate applies. ABA coverage is required, subject to the $35,000/year annual cap. The prohibition on visit limits applies. BCBA or supervised provider required. GBALB state licensure required.
- Members *age 21 and over*: The Georgia mandate does NOT apply. Coverage for adults 21+ is not state-mandated under Ava's Law. Whether coverage is required for members age 21+ depends on MHPAEA parity analysis.

MHPAEA Parity Analysis (Georgia): 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 or before denying coverage to members age 21+ on fully insured plans based solely on the age-21 limit.* If comparable medical/surgical benefits under the same Georgia fully insured plan do not impose equivalent annual dollar caps or age restrictions, the Georgia statutory limitations may be superseded by federal MHPAEA requirements for that plan.

Georgia Medical Necessity Standard: Georgia law defines medical necessity as services that a "prudent provider would provide for the purpose of preventing, diagnosing, or treating illness, injury, or disease" in accordance with generally accepted standards of medical practice. Clinical

criteria must be provided to providers at the time of PA response.

7Z-D: Washington, DC — ABA Mandate (Adult Applicability)

Statute: 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 individual and small group market plans
Age Limits	*None* — no age restrictions on ABA coverage under DC law
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	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; MHPAEA applies; criteria of this policy apply

Adult Applicability Analysis (DC): The DC mandate has *no upper age limit*. For CHP fully insured plans in DC, ABA must be covered for adult members of all ages (18 and over) on non-grandfathered plans, with no annual or lifetime dollar caps, and without classification as educational services. Adult members in DC on applicable fully insured plans are entitled to ABA coverage based solely on medical necessity.

MHPAEA Parity Analysis (DC): 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 for adult members based solely on medical necessity without age or dollar limitations (for non-grandfathered plans).

7Z-E: Maryland — ABA Mandate (Adult Applicability)

Statute: 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* — no annual or lifetime dollar caps; 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 hour floor for adults 19+* (but no upper hour cap or dollar cap applies)
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; MHPAEA applies; criteria of this policy apply

Adult Applicability Analysis (Maryland): Maryland's mandate is the most expansive and most protective for adult members of all CHP operating states. The Maryland mandate:

- Applies to adults of *all ages* — no upper age limit
- Imposes *no annual or lifetime dollar caps* for adult members
- Prohibits denial of ABA on grounds that it is experimental, investigational, or not medically proven — this prohibition expressly applies to adult ABA
- Prohibits reclassification of ABA as "educational" to deny coverage — relevant where adult ABA involves functional skill building
- Requires coverage of ABA as a habilitative service regardless of whether the condition is expected to improve — this provision is particularly relevant for adult maintenance of function

For adult members (19+) on fully insured Maryland plans: no statutory minimum hour floor applies (the 25 hrs/week and 10 hrs/week floors are for children), but CHP applies individualized medical necessity review based on the adult's specific clinical needs, up to the limits in Section 4Z-B-1.

MHPAEA Parity Analysis (Maryland): Maryland's mandate already exceeds federal MHPAEA requirements in its protections for adults. No MHPAEA conflict exists. For CHP fully insured plans in Maryland: (a) ABA must be covered for adult members of all ages; (b) no dollar caps apply; (c) experimental or educational denial rationales are prohibited; (d) maintenance of current function is a covered basis for ABA authorization.

7Z-F: Indiana — ABA Mandate (Adult Applicability)

Statute: 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
ASO Plans	Mandate does NOT apply; MHPAEA applies; criteria of this policy apply

Adult Applicability Analysis (Indiana): The Indiana commercial mandate has *no upper age limit* and *no dollar caps*. For CHP fully insured plans in Indiana, ABA must be covered for adult members of all ages (18 and over), with no annual or lifetime dollar caps. Adult members in Indiana on applicable fully insured plans are entitled to ABA coverage based solely on medical necessity, subject to physician-approved care plan requirement. Indiana BCBA state licensure through IPLA required.

Important Note — Indiana Medicaid Changes (NOT Applicable to CHP Commercial Plans): Significant changes to Indiana Medicaid (IHCP) ABA benefits became effective April 1, 2026, including a 4,000-hour lifetime cap on "Comprehensive ABA" (as defined by Indiana Medicaid as ≥16 hours/week), a 6% ABA provider rate cut, and age restrictions on new Medicaid EPSDT authorizations for adults. These changes *apply exclusively to Indiana Medicaid and do NOT apply to CHP commercial products*. CHP commercial plans in Indiana are governed by the Indiana commercial mandate (IC § 27-8-14.2), which contains no such restrictions.

MHPAEA Parity Analysis (Indiana 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, if applied to commercial plans, would constitute a QTL violation under MHPAEA. CHP commercial plans do not apply this limit.

7Z-G: Ohio — ABA Mandate (Adult Applicability)

Statute: 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; no weekly hour limit stated for members ages 14–20
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
Provider Requirements	Certified Ohio Behavior Analyst (COBA) designation required; COBA requirements can be satisfied by BCBA qualifications; Ohio Board of Psychology oversight
ASO Plans	Mandate does NOT apply; MHPAEA applies; criteria of this policy apply

Adult Applicability Analysis (Ohio): For adult members (18+) on fully insured Ohio plans:

- Members *ages 18, 19, and 20* (under 21): The Ohio mandate generally applies through age 21. The 20-hours/week ABA limit applies to children under age 14; no explicit weekly hour limit is stated for members ages 14–20, though ASD coverage is required through age 21.
- Members *age 21 and over*: The Ohio mandate does NOT apply. Adults 21+ are not covered under Ohio ORC § 3923.84. Coverage for adults 21+ depends on MHPAEA parity analysis.

MHPAEA Parity Analysis (Ohio): The 20-hours/week ABA limit for children under age 14 is a Quantitative Treatment Limitation (QTL) under MHPAEA. The age-21 upper limit is a potential NQTL. *Curative Health Plan will evaluate MHPAEA compliance before applying the Ohio 20-hour/week cap or the age-21 upper 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") further supports this analysis. For adults 21+ on Ohio fully insured plans subject to MHPAEA, coverage determination requires MHPAEA comparative analysis of analogous medical/surgical benefit age limits and service caps.

7Z-H: Adult ABA — State Mandate Summary Table (18 and Over)

State	Statute	Adult (18+) Mandate Coverage	Age-21+ Mandate Coverage	Annual $ Cap (Adults)	Diagnosis-by-Age Requirement	MHPAEA Override Risk
TX	IC § 1355.015	Yes — if diagnosed before age 10; no upper age cap	Yes — no upper age cap if diagnosed before age 10	$36,000/year (members age 10+; diagnosed before age 10)	Diagnosis before 10th birthday	*High* — diagnosis-by-age-10 NQTL; $36,000 cap QTL
FL	FS § 627.6686	18+ only if still in high school; not mandated for adults 18+ not in high school	Not mandated	$36,000/year; $200,000 lifetime	Diagnosed at age 8 or younger	*High* — age-in-high-school NQTL; dollar caps QTL
GA	GA § 33-24-59.10	Yes — ages 18, 19, 20 (under 21)	Not mandated (21+)	$35,000/year	None (annual medical necessity required)	*High* — age-21 upper limit NQTL; $35,000 cap QTL
DC	DC § 31-3271	*Yes — no age limit*	*Yes — no age limit*	*None*	None	*Low* — most MHPAEA-consistent state
MD	MD Ins. § 15-835	*Yes — no age limit*	*Yes — no age limit*	*None*	None	*Low* — mandate already exceeds MHPAEA
IN	IC § 27-8-14.2	*Yes — no age limit (commercial)*	*Yes — no age limit (commercial)*	*None (commercial)*	None	*Low* — no age cap, no dollar cap
OH	ORC § 3923.84	Yes — ages 18, 19, 20 (under 21)	Not mandated (21+)	None (parity required)	None	*High* — age-21 upper limit NQTL; 20-hr/week QTL for under-14

All dollar caps and age limits in the table above are subject to MHPAEA parity analysis for fully insured plans subject to MHPAEA. 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.

7B. Texas — Additional Regulatory Notes (Non-ABA)

• *ECT Additional Requirements:* Texas requires additional physician attestation for ECT under Texas Health & Safety Code. Fully insured and level-funded plans must comply. Treating psychiatrist must document compliance with Texas consent and attestation requirements for ECT. Facilities providing ECT must hold appropriate Texas state certifications.

• *Prior Authorization Reform (HB 3812, 2025):* UR for TX fully insured/level-funded must be by a Texas-licensed physician. Same-specialty review required for medical necessity appeals. Gold Card exemption: providers with ≥90% approval rate over a 12-month evaluation period are exempt from PA for that service.

• *Step Therapy Reform:* Step therapy override process required; override must be granted when clinically justified.

7C. Florida — Additional Regulatory Notes (Non-ABA)

• *External Review:* Florida operates under the HHS-Administered Federal External Review Process alongside state process. Standard external review: 45 days; expedited: 72 hours.

7D. Georgia — Additional Regulatory Notes (Non-ABA)

• *Medical Necessity Standard:* Georgia law defines medical necessity as services that a "prudent provider would provide for the purpose of preventing, diagnosing, or treating illness, injury, or disease" in accordance with generally accepted standards of medical practice. Clinical criteria must be provided to providers at the time of PA response.

7E. ECT State Regulatory Notes

State	ECT Special Requirements
TX	Additional physician attestation for ECT required under Texas Health & Safety Code; treating facility must have state certification
FL	No additional state requirements beyond federal standards
GA	No additional state requirements beyond federal standards
DC	No additional state requirements beyond federal standards
MD	No additional state requirements beyond federal standards
IN	No additional state requirements beyond federal standards
OH	No additional state requirements beyond federal standards

Note: For any ECT request: (1) Confirm the treatment facility has required state certification; (2) Confirm the treating psychiatrist has documented training and experience in ECT; (3) Confirm

anesthesia services are documented; (4) For TX: confirm compliance with Texas physician attestation requirements.

7F. PA Timeline Compliance

All PA decisions under this policy must comply with applicable federal timelines:

- *Standard PA:* Decision within 15 calendar days of receipt of all necessary clinical information
- *Urgent PA:* Decision within 72 hours
- *Texas (fully insured/level-funded):* Same-specialty reviewer for appeals; Gold Card exemption process applies
- *Georgia (fully insured/level-funded):* Response within 7 calendar days (non-urgent); 72 hours (urgent) per O.C.G.A. § 33-64-8

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

ICD-10 Code	Description
F84.0	Autism spectrum disorder
F84.5	Asperger's syndrome (legacy diagnosis; subsumed into ASD under DSM-5-TR)
F84.8	Other pervasive developmental disorders
F84.9	Pervasive developmental disorder, unspecified
F70	Mild intellectual disabilities
F71	Moderate intellectual disabilities
F72	Severe intellectual disabilities
F73	Profound intellectual disabilities
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

ICD-10 Code	Description
F33.2	Major depressive disorder, recurrent, severe without psychotic features
F33.3	Major depressive disorder, recurrent, severe with psychotic features
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
F20.1	Disorganized schizophrenia
F20.2	Catatonic schizophrenia
F20.9	Schizophrenia, unspecified
F25.0	Schizoaffective disorder, bipolar type
F25.1	Schizoaffective disorder, depressive type
F44.2	Dissociative stupor (catatonia)
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
F50.00	Anorexia nervosa, unspecified
F50.01	Anorexia nervosa, restricting type
F50.02	Anorexia nervosa, binge eating/purging type
F50.2	Bulimia nervosa
F60.3	Borderline personality disorder

ICD-10 Code	Description
F60.9	Personality disorder, unspecified
F10.10	Alcohol use disorder, mild
F10.20	Alcohol use disorder, moderate
F10.230	Alcohol use disorder, moderate, with alcohol withdrawal, uncomplicated
F10.231	Alcohol use disorder, moderate, with alcohol withdrawal delirium
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
F14.20	Cocaine use disorder, moderate
F15.10	Other stimulant use disorder, mild
F19.10	Other psychoactive substance use disorder, mild
F19.20	Other psychoactive substance use disorder, moderate
G30.9	Alzheimer's disease, unspecified (for neuropsychological testing)
G31.84	Mild cognitive impairment (for neuropsychological testing)
F06.31	Mood disorder due to known physiological condition with depressive features
S09.90XA	Head injury (for neuropsychological testing — TBI evaluation)
F80.x	Specific developmental disorders of speech and language (co-occurring with ASD)
F90.x	Attention-deficit hyperactivity disorders (co-occurring with ASD)

ASD Diagnoses NOT Covered for ABA Under This Policy:

ICD-10 Code	Description	Reason Not Covered
F84.2	Rett's disorder (Rett syndrome)	NOT classified as ASD under DSM-5-TR; distinct genetic etiology (MECP2 mutation); may be reviewed under separate criteria on a case-by-case basis
F84.3	Other childhood disintegrative disorder	NOT classified as ASD under DSM-5-TR; ABA for this condition not covered under this policy

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 18 and over. Includes original ABA section (Sections 4A, 5A) with general adult ABA medical necessity criteria.
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, with adult-specific clinical and regulatory framing.* Integrated full ABA medical necessity criteria as Section 4Z and Section 5Z. Specific updates include: (1) 36-month diagnostic currency requirement (Section 4Z-A.4); (2) integrated mandatory supervision requirements — 10% BCBA supervision ratio of RBT direct hours, minimum 2 face-to-face contacts/month, direct observation required (Section 4Z-E); (3) mandatory caregiver/support person participation with adult-specific framing — parent of adult, spouse, guardian, residential staff, job coach; minimum 1–4 hours/month of 97156/97157; ≥80% attendance threshold; adult consent considerations documented (Section 4Z-G); (4) required assessment tools — Vineland-3 at baseline and every 6 months; AFLS/VB-MAPP/ABLLS-R criterion-referenced assessment; ADOS-2/ADI-R diagnostic confirmation; FBA for behavior reduction goals (Section 4Z-C); (5) adult weekly hour caps — Focused ABA up to 25 hrs/week for all adults; Comprehensive up to 30 hrs/week for ages 18–21 with justification; up to 25 hrs/week for age 22+ with extraordinary justification (Section 4Z-B-1); (6) code-specific meets criteria for all ABA codes — 97151, 97153, 97155, 97156, 97157, 97158, 0362T, 0373T — with adult-specific application (Section 4Z-D); (7) telehealth code-specific rules documented per code (billable: 97151, 97155, 97156, 97157; in-person required: 97153, 0362T, 0373T) (Sections 3A, 4Z-D); (8) adult-specific treatment plan elements emphasizing vocational/independent living goals (Section 4Z-F); (9) reauthorization criteria with 6-month authorization periods and required outcome measures (Vineland-3, criterion-referenced instrument) (Section 4Z-J); (10) expanded exclusions list including non-evidence-based treatments with adult-specific framing (Section 5Z-C); (11) concurrent billing restrictions aligned with NCCI (Section 3A, 5Z-F); (12) MHPAEA limitations not applied to adult ABA (Section 5Z-E); (13) concurrent services coordination requirements with quarterly documentation standard (Section 4Z-L); (14) daily session note documentation standards (Section 5Z-G); (15) detailed state mandate analysis for all 7 operating states with adult applicability emphasis — TX (diagnosis before age 10 required; $36,000/year cap subject to MHPAEA); FL (under-18 or still in high school; dollar caps subject to MHPAEA); GA Ava's Law (under-21; $35,000/year subject to MHPAEA); DC (no age limit; no dollar caps); MD § 15-835 (no age limit; no dollar caps; most expansive); IN (no age limit; no dollar caps; commercial); OH (under-21; age-21 cap subject to MHPAEA) (Section 7Z); (16) age-specific criteria for 18–21 transition and 22+ adult ABA with higher documentation standard but clear coverage basis and MHPAEA protection (Section 4Z-K).

REFERENCES

Clinical Guidelines — Behavioral Health (Non-ABA)

1. American Psychiatric Association (APA). Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Text Revision (DSM-5-TR). APA Publishing; 2022.

2. American Psychiatric Association (APA). Clinical Practice Guidelines. https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines - Schizophrenia (3rd Ed, 2021); Alcohol Use Disorder (2018); Eating Disorders (2023); Borderline Personality Disorder (2025)

3. American Psychiatric Association (APA). APA Task Force on ECT Comments to FDA on ECT Reclassification. APA; March 2016. https://www.psychiatry.org/File%20Library/Psychiatrists/Advocacy/Federal/APA-FDA-ECT-reclassification-comments-03102016.pdf

4. McClintock SM, Reti IM, Carpenter LL, et al. Consensus Recommendations for the Clinical Application of Repetitive Transcranial Magnetic Stimulation (rTMS) in the Treatment of Depression. Journal of Clinical Psychiatry. 2018;79(1):16cs10905. PMC5846193.

https://pmc.ncbi.nlm.nih.gov/articles/PMC5846193/

5. American Society of Addiction Medicine (ASAM). The ASAM Criteria, 4th Edition. ASAM; 2023. https://www.asam.org/asam-criteria/asam-criteria-4th-edition

6. BrainsWay. BrainsWay Receives FDA Clearance for Accelerated Deep TMS Protocol (September 2025). https://www.brainsway.com/news_events/brainsway-receives-fda-clearance-for-accelerated-deep-tms-protocol-for-non-invasive-treatment-of-major-depressive-disorder-mdd/

7. Centers for Medicare & Medicaid Services (CMS). LCD L34998 — Transcranial Magnetic Stimulation for Adults with MDD. CMS. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=34998

8. American Psychiatric Nurses Association (APNA). Electroconvulsive Therapy (ECT) Treatment Considerations. APNA; January 2026. https://www.apna.org/electroconvulsive-therapy-ect-treatment-considerations/

9. Leiknes KA, Jarosh-von Schweder L, Høie B. Evidence review: ECT in catatonia. Brain Behav. 2012;2(3):283-344. PMC7526008. https://pmc.ncbi.nlm.nih.gov/articles/PMC7526008/

10. National Institute of Mental Health (NIMH). StatPearls: Electroconvulsive Therapy. NCBI Bookshelf; 2024. https://www.ncbi.nlm.nih.gov/books/NBK538266/

11. Centers for Medicare & Medicaid Services (CMS). LCD L34570 — Psychiatric Inpatient Hospitalization. CMS; 2024. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdId=34570&ver=44

12. Centers for Medicare & Medicaid Services (CMS). LCD L33626 — Psychiatric Partial Hospitalization Programs. CMS. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33626

13. Centers for Medicare & Medicaid Services (CMS). Coverage Article A57520 — Psychiatric Diagnostic Evaluation. CMS. https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=57520&ver=43

14. American Psychological Association (APA). Psychological and Neuropsychological Testing Billing and Coding Guide 2024. APA Services. https://www.apaservices.org/practice/reimbursement/health-codes/testing/billing-coding.pdf

15. American Psychological Association (APA-Psych). Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts. APA; 2019. https://www.apa.org/depression-guideline

16. American Psychological Association (APA-Psych). Clinical Practice Guideline for the Treatment of PTSD. APA; 2017 (updated 2025). https://www.apa.org

17. U.S. Department of Veterans Affairs / Department of Defense. VA/DoD Clinical Practice Guideline for the Management of PTSD. VA/DoD; 2023. https://www.healthquality.va.gov/guidelines/MH/ptsd/

Clinical Guidelines — ABA Therapy

18. Behavior Analyst Certification Board (BACB). Ethics Code for Behavior Analysts (Effective January 1, 2022). BACB. https://www.bacb.com/ethics-information/ethics-codes/

19. Behavior Analyst Certification Board (BACB). U.S. Licensure of Behavior Analysts (Updated March 2026). BACB. https://www.bacb.com/u-s-licensure-of-behavior-analysts/

20. Behavior Analyst Certification Board (BACB). Treatment of Autism and Other Developmental Disabilities. BACB. https://www.bacb.com/about-behavior-analysis/treatment-of-autism-and-other-developmental-disabilities/

21. Council of Autism Service Providers (CASP). ABA Practice Guidelines for the Treatment of Autism Spectrum Disorder, Version 3.0 (Released May 2024). CASP. https://www.casproviders.org/asd-guidelines

22. Behavior Analyst Certification Board (BACB). Clarifications to the ABA Practice Guidelines for the Treatment of Autism Spectrum Disorder, 2nd Ed. BACB; 2020. https://assets.bacb.com/wp-content/uploads/2020/05/Clarifications_ASD_Practice_Guidelines_2nd_ed.pdf

23. American Academy of Pediatrics (AAP). Clinical Report on Management of Children with Autism Spectrum Disorders (Updated 2020). AAP. https://www.hopebridge.com/blog/aap-autism-guidelines-for-early-intervention/

24. American Academy of Child and Adolescent Psychiatry (AACAP). Practice Parameters for the Assessment and Treatment of Children and Adolescents with Autism Spectrum Disorder. AACAP. https://www.aacap.org/aacap/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx

25. National Professional Development Center on Autism Spectrum Disorder (NPDC). Evidence-Based Practices for Children, Youth, and Young Adults with ASD. Frank Porter Graham Child Development Institute, UNC. https://autismpdc.fpg.unc.edu/ebps/

26. National Autism Center. National Standards Project, Phase 2 (2015). National Autism Center. https://www.nationalautismcenter.org/national-standards-project/

27. ABA Coding Coalition. ABA Coding FAQs. https://abacodes.org/frequently-asked-questions/

Peer-Reviewed Evidence — ABA

28. Lovaas OI. Behavioral Treatment and Normal Educational and Intellectual Functioning in Young Autistic Children. Journal of Consulting and Clinical Psychology. 1987;55(1):3–9. https://lovaas.com/research/

29. McEachin JJ, Smith T, Lovaas OI. Long-Term Outcome for Children with Autism Who Received Early Intensive Behavioral Treatment. American Journal on Mental Retardation. 1993;97(4):359–372.

30. Reichow B, Hume K, Barton EE, Boyd BA. Early Intensive Behavioral Intervention (EIBI) for Young Children with Autism Spectrum Disorders (ASD). Cochrane Database of Systematic

Reviews. 2018;Issue 5, Art. No.: CD009260. https://pmc.ncbi.nlm.nih.gov/articles/PMC6494600/

31. National Academies of Sciences, Engineering, and Medicine (NASEM). Evidence Base for Applied Behavior Analysis (Chapter in TRICARE Coverage Review). National Academies Press; 2025. https://www.ncbi.nlm.nih.gov/books/NBK619281/

32. Wong C, Odom SL, Hume KA, et al. Evidence-Based Practices for Children, Youth, and Young Adults with Autism Spectrum Disorder: A Comprehensive Review. Journal of Autism and Developmental Disorders. 2015/2021. https://pmc.ncbi.nlm.nih.gov/articles/PMC12209169/

33. Kornack J, Holden K, Hubbard JP, et al. The Race to Preserve Best-Practice ABA Services: Addressing NQTL Violations Under MHPAEA. Behavior Analysis in Practice. 2024. PMC12209169. https://pmc.ncbi.nlm.nih.gov/articles/PMC12209169/

MHPAEA Federal Law and Guidance

34. U.S. Departments of Labor, HHS, and Treasury. Mental Health Parity and Addiction Equity Act (MHPAEA). Public Law 110-343; 2008. CMS overview: https://www.cms.gov/marketplace/private-health-insurance/mental-health-parity-addiction-equity

35. U.S. Departments of Labor, HHS, and Treasury. Final Rules Under the Mental Health Parity and Addiction Equity Act of 2008. 78 Federal Register 68240 (November 13, 2013).

36. U.S. Departments of Labor, HHS, and Treasury. Requirements Related to the Mental Health Parity and Addiction Equity Act (2024 Final Rule). 89 Federal Register 72736 (September 23, 2024). https://www.federalregister.gov/documents/2024/09/23/2024-20612/requirements-related-to-the-mental-health-parity-and-addiction-equity-act

37. Centers for Medicare & Medicaid Services (CMS). MHPAEA Overview. CMS. https://www.cms.gov/marketplace/private-health-insurance/mental-health-parity-addiction-equity

38. U.S. Department of Labor (DOL). Final Rules Under the Mental Health Parity and Addiction Equity Act (MHPAEA) — Fact Sheet. DOL; September 2024. https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/final-rules-under-the-mental-health-parity-and-addiction-equity-act

39. Ballard Spahr LLP. Non-Quantitative Treatment Limitation Rules Under MHPAEA — Summary. https://www.ballardspahr.com/landing-pages/nonquantitative-treatment-limitation-rules-under-the-mental-health-parity-and-addiction-equity-act

State Statutes and Regulatory Sources

40. Texas Insurance Code § 1355.015 — Autism Spectrum Disorder (SB 1484, 2013). Texas Legislature Online. https://statutes.capitol.texas.gov/

41. Florida Statutes § 627.6686 — Autism Spectrum Disorder Coverage (2024 text). Florida Senate. https://www.flsenate.gov/Laws/Statutes/2024/627.6686

42. Georgia Code § 33-24-59.10 — Ava's Law — Coverage for Autism Spectrum Disorder (2024). Justia Law. https://law.justia.com/codes/georgia/title-33/chapter-24/article-1/section-33-24-59-10/

43. DC Code § 31-3271 et seq. — Autism Insurance Coverage (effective January 1, 2014). Referenced at: https://www.autismspeaks.org/district-columbia-state-regulated-insurance-coverage

44. Maryland Insurance Code § 15-835 — Autism Spectrum Disorder Coverage (SB 946, 2019). Referenced at: https://www.autismspeaks.org/maryland-state-regulated-insurance-coverage

45. Indiana Code § 27-8-14.2 — Coverage for Autism Spectrum Disorders. Justia Law. https://law.justia.com/codes/indiana/title-27/article-8/chapter-14-2/

46. Indiana Family and Social Services Administration (FSSA). Indiana IHCP Provider Bulletin BT202627 — Applied Behavior Analysis Therapy Changes (February 26, 2026). Indiana Medicaid. https://www.in.gov/medicaid/providers/files/bulletins/BT202627.pdf

47. Ohio Revised Code § 3923.84 — Coverage for Autism Spectrum Disorder (Updated February 18, 2025). Ohio Laws. https://codes.ohio.gov/ohio-revised-code/section-3923.84

48. Texas Department of Insurance (TDI). Utilization Review Rules 28 TAC Chapter 19. TDI; 2022. https://www.tdi.texas.gov/rules/2022/documents/20227434.pdf

49. Texas Legislature. HB 3812 (89th Legislature, 2025) — Gold Card PA Exemption Amendments. Texas Policy Research. https://www.texaspolicyresearch.com/bills/89th-legislature-hb-3812/

50. Applied Behavior Analysis Education. State-by-State Guide to Autism Insurance Laws (Updated March 2026). ABAedu.org. https://www.appliedbehavioranalysisedu.org/state-by-state-guide-to-autism-insurance-laws/

51. Autism Speaks. State-Regulated Health Insurance Coverage for Autism. Autism Speaks. https://www.autismspeaks.org/state-regulated-health-benefit-plans

52. National Conference of State Legislatures (NCSL). Autism and Insurance Coverage State Laws. NCSL. https://www.ncsl.org/health/autism-and-insurance-coverage-state-laws

53. Behavioral Health Business. States Refine ABA Coverage: New Hour Caps, Age Limits, Rate Cuts. BHBusiness; January 22, 2026. https://bhbusiness.com/2026/01/22/states-refine-aba-coverage-new-hour-caps-age-limits-rate-cuts/

54. Autism Legal Resource Center. State Healthcare Coverage Guide. https://www.autismlegalresourcecenter.com/resources/autism-healthcare-info/

55. Level of Care Utilization System (LOCUS). Lucet Health Medical Necessity Criteria 2025 — LOCUS Framework. https://lucethealth.com/providers/resources/mnc-2025/

56. ASAM Criteria 3rd Edition Matrix (prior edition reference). ISSUP Document. https://www.issup.net/files/2023-09/ASAM%203rd%20Ed%20Matrix_0.pdf

57. PraxisNotes. A Comprehensive Guide to ABA Progress Reports for Insurance Reauthorization. PraxisNotes. https://www.praxisnotes.com/resources/guide-aba-progress-reports-reauthorization

Policy CHP-BEH-2026-002 | Curative Health Plan | Effective April 1, 2026 | Version 2.0 | Last Reviewed April 27, 2026

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. The ABA-specific criteria in Section 4Z and Section 5Z of this policy are derived from CHP-BEH-2026-003 ABA Therapy v2.0 and have been adapted for the 18-and-over member population with adult-specific clinical and regulatory framing. 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.