Document ID: AETAMA-081826	Title: AMA 7000.11 Louisiana Applied Behavior Analysis	
Parent Documents: N/A		
Effective Date: 01/20/2022	Last Review Date: 03/06/2025	Business Process Owner (BPO):
Exhibit(s):		
Document Type: Policy and Procedure		

PURPOSE

The purpose of this policy is to define Aetna Better Health's clinical requirements for the prior authorization of Applied Behavior Analysis (ABA) services.

SCOPE

The scope of this policy applies to the Louisiana Prior Authorization staff and all colleagues processing Louisiana authorization requests for Applied Behavior Analysis (ABA) services.

POLICY

It is the policy of the plan that specific state directives are used when processing authorization requests for Applied Behavior Analysis (ABA) services. Louisiana state qualifications, authorization and documentation requirements must be met. It defines additional Louisiana state qualifications and authorization and documentation requirements.

STANDARD

ABA therapy is the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including direct observation, measurement, and functional analysis of the relations between environment and behavior. ABA-based therapies teach skills through the use of behavioral observation and reinforcement or prompting to teach each step of targeted behavior. ABA is a covered service for members under the age of 21 who:

- Exhibit the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities (e.g., aggression, self-injury, elopement, etc.);
- Have been diagnosed with a condition for which ABA-based therapy services are recognized as therapeutically appropriate, including autism spectrum disorder, by a qualified health care professional;
- Had a comprehensive diagnostic evaluation by a qualified health care professional; and
- Have a prescription for ABA-based therapy services ordered by a qualified health care professional.[1]

Prior Authorization of Applied Behavior Analysis (ABA) Services

ABA requires prior authorization. If a member has primary coverage available for ABA services through another insurer, the health plan will bypass the prior authorization process and acknowledge the prior authorization granted by the primary insurer.

[1] LDH Applied Behavior Analysis Provider Manual, Section 4.0, page 1; Section 4.1, page 1; and Section 4.2, page 1

Prior authorization (PA) is a two-fold process. An authorization is first requested for approval to perform a functional assessment and to develop a behavior treatment plan. A second authorization is needed for approval to provide the ABA-based derived therapy services.

Prior to requesting ABA services, the member must have documentation indicating medical necessity for the services through a completed comprehensive diagnostic evaluation (CDE) that has been performed by a qualified health care professional (QHCP). A QHCP is defined as a:

1. Pediatricians using the MCHAT-R/F, and clinical judgment may diagnosis and complete a CDE. For children who receive a high-risk score of ≥ 8 on the MCHATR/F, pediatricians can independently make a diagnosis of autism (if their clinical judgment concurs with this score). For children who receive a moderate risk score of 3 to 7 on the MCHAT-R/F, pediatricians can complete the MCHAT-R/F followup interview, and based on their confidence in their clinical judgment, either independently make a diagnosis of autism or refer to a subspecialist listed below for a diagnostic evaluation:
    a. Pediatric Neurologist;
    b. Developmental Pediatrician;
    c. Psychologist (including a Medical Psychologist);
    d. Psychiatrist (particularly Pediatric and Child Psychiatrist);
    e. A pediatrician under a joint working agreement with an interdisciplinary team of providers who are qualified to diagnose developmental disabilities;
    f. Nurse Practitioner practicing under the supervision of a Pediatric Neurologist Developmental Pediatrician, Psychologist, or Psychiatrist; or
    g. Licensed individual, including Speech and Language Pathologist, Licensed Clinical Social Worker, or Licensed Professional Counselor, who meets the requirements of a QHCP when:
        i. The individual's scope of practice includes a differential diagnosis of Autism Spectrum Disorder and comorbid disorders for the age and/or cognitive level of the beneficiary;
        ii. The individual has at least two years of experience providing such diagnostic assessments and treatments or is being supervised by someone who is listed as a QHCP under 1-5 above; and
        iii. If the licensed individual is working under the supervision of a QHCP, the QHCP must sign off on the CDE as having reviewed the document and being in agreement with the diagnosis and recommendation.

The CDE must include at a minimum:

• A thorough clinical history with the informed parent/caregiver, inclusive of developmental and psychosocial history;

• Direct observation of the beneficiary, to include but not be limited to, assessment of current functioning in the areas of social and communicative behaviors and play or peer interactive behaviors;

• A review of available records;
• A valid Diagnostic and Statistical Manual of Mental Disorders, (DSM) V (or current edition) diagnosis;
• Justification/rationale for referral/non-referral for an ABA functional assessment and possible ABA services; and
• Recommendations for any additional treatment, care or services, specialty medical or behavioral referrals, specialty consultations, and/or any additional recommended standardized measures, labs or other diagnostic evaluations considered clinically appropriate and/or medically necessary.[2]

The licensed professional supervising treatment is required to perform a functional assessment of the beneficiary utilizing the outcomes from the CDE, and develop a behavior treatment plan. Services for "Behavior Identification Assessment" must be prior authorized by Aetna Better Health. Once services commence, additional assessments at a minimum shall occur every six months. The authorization period for such assessments shall not exceed 180 days. In exceptional circumstances, at the discretion of Aetna Better Health, an additional assessment may be authorized.

The behavior identification supporting assessment must be prior authorized. Supporting assessments may be approved to allow technicians to gather information that support the licensed professional completing the assessment. The authorization period for such assessments shall not exceed 180 days. Behavior identification supporting assessment conducted with two or more technicians, must be prior authorized and treated in the same manner as the behavior identification supporting assessment above. However, such assessment may be administered by the physician or other QHCP who is on-site but not necessarily face-to-face; with the assistance of two or more technicians. This is only medically necessary when the beneficiary's behavior is so destructive that it requires the presence of a team and an environment customizable to the beneficiary's behavior. All three assessment services can occur on the same day and continue as prior authorized until the assessment is completed.[3] Aetna Better Health utilization review staff authorizes up to sixteen (16) units of CPT 97151 – "Behavior identification assessment, administered by a physician or other qualified health care professional". Requests for more than 16 units of CPT 97151 require medical director review.

A separate authorization request must be submitted by the ABA provider to request approval to provide the ABA-based therapy services to the member. This authorization request must include:

- The CDE
- The behavioral treatment plan
- The IEP
- The waiver plan profile table and the schedule from the certified plan of care (if the beneficiary is in a waiver and services are being requested that will occur at the same time as waiver services).

[2] LDH Applied Behavior Analysis Provider Manual, Section 4.1, page 1-3
[3] LDH Applied Behavior Analysis Provider Manual, Section 4.1, page 3-4

Authorizations for ABA-derived therapy services will be authorized for a time period not to exceed 180 days. Members have the right to change providers every 180 days unless a change is requested for good cause. If a provider change is requested based on good cause before the authorization period ends, the member or case manager must contact the Aetna Better Health. Good Cause is defined as allegation of abuse, member doesn't progress, new provider opens in area that previously lacked access, or when a dispute arises between the parent/caregiver and provider that cannot be resolved[4].

The behavior treatment plan identifies the treatment goals along with providing instructions to increase or decrease the targeted behaviors. The behavior treatment plan must:

- Be person-centered and based upon individualized goals;
- Delineate the frequency of baseline behaviors and the treatment development plan to address the behaviors;
- Identify long-term, intermediate, and short-term goals and objectives that are behaviorally defined;
- Identify the criteria that will be used to measure achievement of behavior objectives;
- Clearly identify the schedule of services planned and the individual providers responsible for delivering the services;
- Include care coordination, involving the parent(s) or caregiver(s), school, state disability programs, and others as applicable;
- Include parent/caregiver training, support, education, and participation;
- Identify objectives that are specific, measurable, based upon clinical observations of the outcome measurement assessment, and tailored to the beneficiary; and
- Ensure that interventions are consistent with ABA techniques.[5]

The provider may use the LDH treatment plan template or their own form. If the provider chooses to use their own form, the provider must address ALL of the relevant information specified in the LDH treatment plan template. The behavior treatment plan must indicate that direct observation occurred and describe what happened during the direct observation. If there are behaviors being reported that did not occur and these behaviors are being addressed in the behavior treatment plan, indicate all situations and frequencies at which these behaviors have occurred and have been documented. If there is documentation from another source, that documentation must be attached. If there is any other evidence of the behaviors observed during the direct observation and that are proof of these behaviors, these must be reported on the behavior treatment plan as well. The behavior treatment plan shall include a weekly schedule detailing the number of expected hours per week and the location for the requested ABA services. In addition, the provider shall indicate both the intensity and frequency of the therapy being requested and the justification for this level of service. When developing a treatment plan, it is necessary to request only services that are medically necessary as determined through the assessment. Any model of ABA services can be approved if it achieves the goals set forth in the assessment. All services do not need to be part of the treatment plan, or used in conjunction with

[4] LDH Applied Behavior Analysis Provider Manual, Section 4.3, page 1-2
[5] LDH Applied Behavior Analysis Provider Manual, Section 4.1, page 3-4

each other, unless technician services are being provided. If technician services are being provided, supervision by a licensed behavior analyst must be a part of the treatment plan.[6]

Medical Necessity Criteria

The medical necessity criterion used to authorize ABA services is the LDH Applied Behavior Analysis Provider Manual.

APPLICABLE CPT/HCPCS CODES

This policy applies the additional definitions, qualifications, criteria and documentation requirements to the procedure codes listed below. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT/HCPCS	Description
97151	Behavior identification assessment, administered by a physician or other qualified health care professional
97152	Behavior identification supporting assessment, administered by one technician under direction of a physician or other qualified health care professional.
0362T	Behavior identification supporting assessment, administered by the physician or other qualified health care provider who is on-site but no necessarily face-to-face; with the assistance of two or more technicians.
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional.
0373T	Adaptive behavior treatment by protocol, administered by the physician or other qualified health care provider who is on-site but no necessarily face-to-face; with the assistance of two or more technicians.
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional.

[6] LDH Applied Behavior Analysis Provider Manual, Section 4.1, page 4-5

97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional.
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present)
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)
97158	Group adaptive treatment with protocol modification, administered by physician or other qualified health care professional

DEFINITIONS:

Prior Authorization	Process in which providers must obtain approval from prior to services provided.

References/Resources

- 2023 Louisiana Medicaid Managed Care Organization Statement of Work
- Louisiana Department of Health (LDH) ABA Provider Manual, revised 02/14/2025

REVIEW AND REVISION HISTORY

Date	Revision No.	Reason for Change	Sections Affected
01/2022	New Policy		
01/2023	1	Added History log; Added additional language for prior authorization regarding units for assessments and requirements for authorization requests; Removed unnecessary language: Aetna Better Health Responsibilities and Operating Protocol sections; Updated with 2023 Louisiana Medicaid Managed Care Organization Model Contract reference; Updated purpose, objectives, and references sections for clarity.	All
05/2024	2	Added additional information regarding service authorization process; Added in updated CEO and Chief Medical Officer; Removed references to MCG criteria.	All
03/2025	3	Added additional information to expand the definition of qualified health care professionals (QHCP)	All

EXHIBIT(S):