North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Coverage for Applied Behavior Analysis

Board of Trustees Meeting

May 30, 2014

A Division of the Department of State Treasurer

Overview of the Recommendation Process

- Request to consider coverage for Applied Behavior Analysis (ABA) from Autism Speaks
- Directive from SHP BOT to SHP staff to explore coverage for ABA
- Development of Proposed Benefit
  - Review of HB 498
  - Review of Current Coverage for Autism Spectrum Disorder (ASD)
  - Review of Value Options clinical criteria for coverage of ABA
  - Discussions with representatives from: TEACCH, BCBSNC, Value Options, Autism Speaks, NC Psychology Association, Fiscal Research Division of the General Assembly
  - Review of NC law as it relates to the provision of ABA
  - Review of Value Options ABA credentialing criteria (BCBA and BCaBA)
  - Drafting of proposed benefit
  - Actuarial analysis of financial impact to SHP for ABA coverage
- Recommendation to SHP BOT to cover ABA

Contents of Information Packet

- Power Point Presentation dated 5/30/14
- HB 498
- Proposed Benefit language for Benefit Booklet
- Value Options Clinical Criteria for ABA
- Applied Behavior Analyst Credentialing Criteria (Applies only if required by State where treatment is given.)
- Applicable Billing Codes (AMA, and BCBSNJ)
- Bibliography of Reviews of the Evidence for Early Intensive Behavioral Intervention
- Analysis of the Evidence Base for ABA and EIBI for Autism
- Actuarial Note from Segal
- ASD Screening Tools

ASD and ABA at a Glance

- CDC reports 1 in 68 children were identified with ASD in 2010; that is 30% higher than the 1 in 88 estimate for 2008
- Currently 37 other states have legislation requiring coverage of ABA
- ASD can cause significant social, communication and behavioral challenges
- There are no medications that can cure or even treat ASD
- Evidence suggests that early intervention programs are beneficial for children with Autism
- ABA encourages positive behaviors and discourages negative behaviors and includes: Discrete Trial Training (DTT), Early Intensive Behavioral Intervention (EIBI), Pivotal Response Training (PRT) and Verbal Behavior Intervention (VBI)

Autism Spectrum Disorder

- Any of the autism spectrum disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the most recent edition of the International Statistical Classification of Diseases and Related Health Problems. (source: HB 498)
- ASD includes: autistic disorder, pervasive developmental disorder not otherwise specified, and Asperger syndrome (source: CDC, DSM V)

Current Coverage for Autism Spectrum Disorder

Coverage for Autism Spectrum Disorder (ASD) is consistent with coverage for other medical conditions or mental health disorders meaning that we cover medically necessary treatment as described in the benefit booklet. Relevant State Health Plan (SHP) coverage includes:

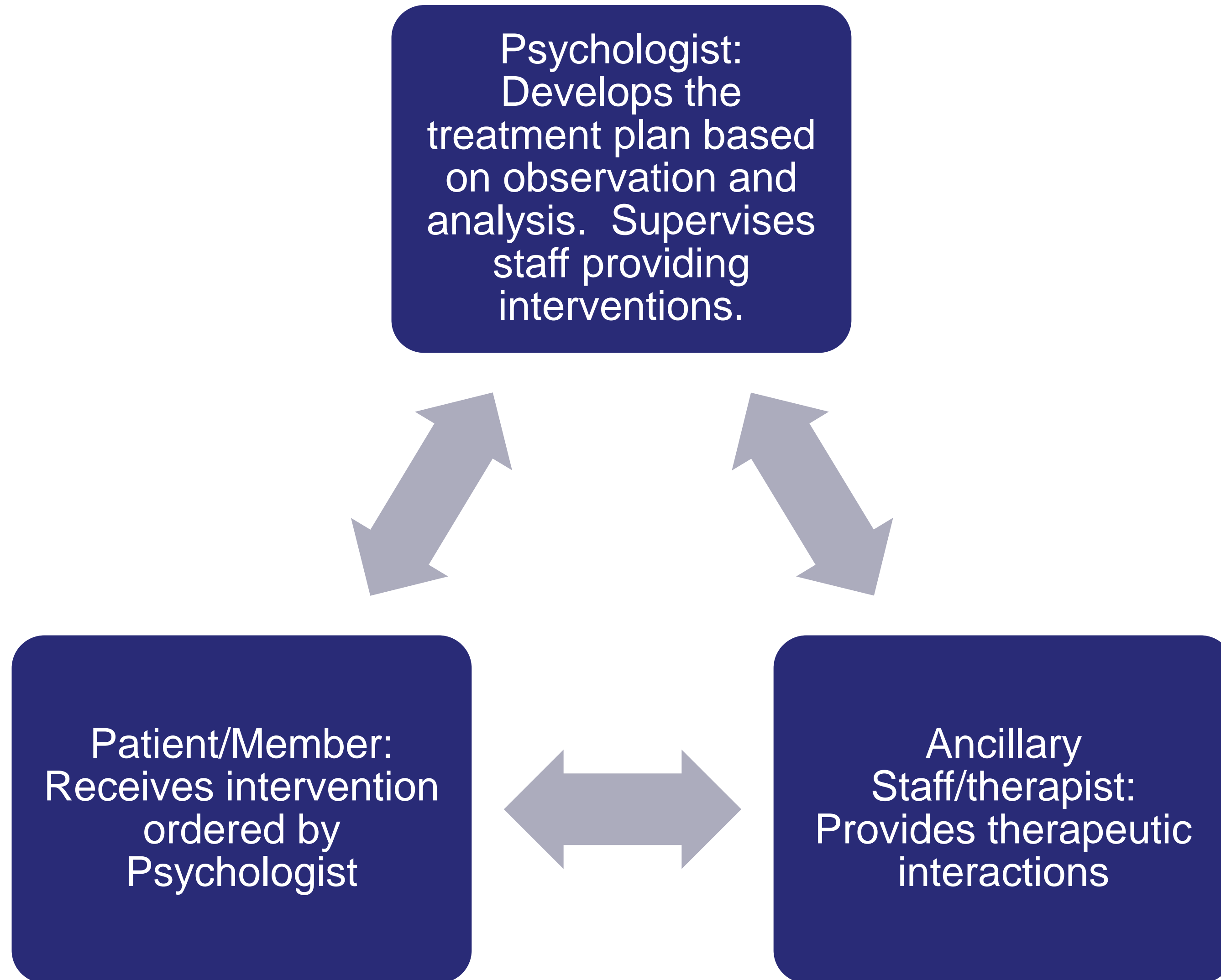
- Speech therapy
- Occupational therapy
- Medical evaluation and treatment
- Mental health evaluation and treatment

Limitations and exclusions to coverage may apply and are listed in the benefit booklet. Currently, Applied Behavior Analysis (ABA) is excluded from coverage.

Applied Behavior Analysis

- ABA is a systematic and structured strategy for addressing challenging behavior problems often found in individuals with ASD.
- Such challenging behavioral problems are culturally abnormal behaviors of such an intensity, frequency or duration that the physical safety of the individual or others is likely threatened, or,
- Behavior which is likely to seriously limit the ability to participate in common social activities such as the educational system and in addition the individual may be denied access to, ordinary community facilities.
- The ABA approach relies on applying experimentally derived principles of behaviorism to modify behavior.

ABA in practice = Analysis + Intervention



Who can provide ABA in North Carolina?

- The Practice of Psychology: The observation, description, evaluation, interpretation, or modification of human behavior by the application of psychological principles, methods, and procedures for the purpose of preventing or eliminating symptomatic, maladaptive, or undesired behavior or enhancing interpersonal relationship, work and life adjustment, personal effectiveness, behavior health, or mental health. The practice of psychology includes, but is not limited to: psychological testing and the evaluation or assessment of personal characteristics such as intelligence, personality, abilities, interests, aptitudes, and neuropsychological functioning; counseling, psychoanalysis, psychotherapy, hypnosis, biofeedback, and behavior analysis and therapy…*NCGS §90-270.2*
- Board Certified Behavior Analysts and Board Certified Assistant Behavior Analysts are not licensed or otherwise authorized in North Carolina to provide ABA.

Supervision of Ancillary staff by a Psychologist

- "Psychologist" includes licensed psychologists (provisional and permanent) and licensed psychological associates, or temporary licensees
- A psychologist may employ or supervise unlicensed individuals to provide ancillary services; the psychologist retains full professional responsibility for ancillary services rendered
- The psychologist is required to have face to face contact with all recipients of services provided by unlicensed ancillary staff
- Failure of any psychologist to train ancillary services personnel, to ensure training has occurred, or to supervise ancillary services personnel may subject that psychologist to disciplinary action

21 NCAC 54.2801

Proposed Benefit Design for ABA

Coverage will be provided for Applied Behavior Analysis when:

- The member is younger than age 26, and
- Diagnosed with ASD by a licensed physician (MD or DO) or a licensed doctoral level clinical psychologist (PsyD or PhD) utilizing results from a face-to-face evaluation and a clinically recognized, validated tool accepted by the Mental Health Care Manager, and
- Treatment is determined by the Mental Health Care Manager to be medically necessary.

Coverage for ABA is limited to a maximum of $36,000 per benefit year and is only available in-network.

Coverage is subject to copay, deductible and coinsurance as applicable (depends on ABA component and place of service).

Applied Behavior Analysis Exclusions

Treatment for the following is not covered:

- Members with medical conditions or impairments that would prevent beneficial utilization of services
- Members requiring 24 hour medical/nursing monitoring or procedures in a hospital setting

ABA will not be certified for the following services:

- Speech therapy
- Occupational therapy
- Vocational rehabilitation
- Supportive respite care
- Recreational therapy
- Orientation and mobility
- Respite Care
- Equine therapy/Hippotherapy
- Dolphin therapy
- Service Animals
- Other educational services

Medical Necessity Criteria – Initial Approval

All of the following criteria must be met:

- Verified diagnosis of ASD
- Display of a “severe challenging behavior” that either 1) presents a health or safety risk to self or others or 2) significantly interferes with socially acceptable activities in the home or community due to the objectionable nature of the behavior.
- Less intensive forms of behavioral treatment or therapy have not been sufficient or are not appropriate to reduce the interfering behaviors, increase pro-social behaviors, or to maintain desired behaviors.
- There is a reasonable expectation of the part of the treating provider that the behavior will improve or the individual will receive maximum benefit through the use of ABA.
- Parent/caregiver training and support is included in the treatment plan with documented plans that skills transfer to the parent/caregiver will occur.

Medical Necessity Criteria - Initial Approval

- The treatment plan must be individualized with measurable objectives. Interventions emphasize generalization of skill and focus on the development of spontaneous social communication, adaptive skills and appropriate behaviors and include a focus that:
  - Is child centered, strengths based, family inclusive, community based, culturally competent, and provided in the least restrictive setting
  - Targets specific behaviors (including frequency, rate, symptom intensity, duration)
  - Incorporates objective baseline and quantifiable progress measures
  - Describes detailed behavioral interventions, reinforcers, strategies for generalization of skills beyond the ABA sessions
  - Coordinates ancillary services and transition plans

Medical Necessity Criteria - Continuing Treatment

- The individual's condition continues to meet admission criteria for ABA, either due to continuation of presenting problems, or appearance of new problems or symptoms.
- There is reasonable expectation that the individual will benefit from the continuation of ABA services.
- Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated. The treatment plan is updated based on treatment progress including the addition of new target behaviors.
- All services and treatment interventions are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice. Expected benefit from all relevant modalities is documented.

Medical Necessity Criteria - Continuing Treatment

- Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms or there are clear benefits to treatment, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident.
- There is documented skills transfer to the individual and treatment transition planning from the beginning of treatment.
- There is a documented attempt at coordination of care with relevant providers/caretakers, etc., when appropriate. If coordination is not successful, the reasons are documented.
- Unless contraindicated, family and/or significant other are actively involved in the treatment as required by the treatment plan, or there are active efforts being made and documented to involve them.

Discharge Criteria

- The individual has achieved adequate stabilization of the challenging behavior and less-intensive modes of treatment are appropriate and indicated.
- The individual no longer meets admission criteria, or meets criteria for a less or more intensive services.
- Treatment is making symptoms persistently worse.
- The individual is not making progress toward treatment goals, as demonstrated by the absence of any documented meaningful (i.e., durable and generalized) measurable improvement or stabilization of challenging behavior and there is no reasonable expectation of progress.

Network Considerations

Plan staff recommends coverage be available in-network only.

- If the benefit is approved, BCBSNC will work on developing a network of ABA providers. This will include:
  - Credentialing and contracting with qualified providers who are not already in the network
  - Amending current contracts with qualified providers to include fee schedules for ABA billing codes

Other considerations

- Billing Codes have not yet been finalized by the American Medical Association (AMA). Until finalized, temporary codes published by AMA will be utilized.
- Treatment limitations on ABA will result in loss of mental health parity and the Plan will have to exercise the opt-out that is allowed under federal law.

Estimated Cost for ABA Coverage

Plan Design	Projected Cost Impact (in Millions) each Calendar Year				
	2015	2016	2017	2018	2019
$36,000 annual maximum	$4.0	$5.0	$5.2	$5.5	$5.8

Recommendation for Coverage of ABA

Plan staff recommends coverage of ABA for the treatment of Autism Spectrum Disorder as described on slide 11 and as set forth in the draft benefit booklet excerpt for Mental Health and Chemical Dependency Benefits.

Appendix

Comparison of Benefit Design to HB 498

Benefit Component	HB 498	SHP Considered Benefit	Explanation of Difference
Age requirements	Diagnosis: Prior to Age 8 Treatment: Age 23 (G.S. 58-3-192.b)	Diagnosis and Treatment up to Age 26	Age changed to match dependent eligibility
Utilization management	An insurer shall have the right to request a review of that treatment not more than once annually, unless the insurer and the individual's licensed physician or the individual's licensed psychologist agree that a more frequent review is necessary. Any such agreement regarding the right to review a treatment plan more frequently shall apply only to a particular insured being treated for an autism spectrum disorder and shall not apply to all individuals being treated for an autism spectrum disorder by a physician or psychologist. The cost of obtaining any review shall be borne by the insurer. (G.S. 58-3-192.h)	Consistent with SHP utilization management policies through BCBSNC and Value Options. Prior authorization will be required for the initial treatment plan as well as all continuing treatment.	Prior authorization for both initial and continuing treatment is necessary to ensure that therapy is appropriate for the individual and that progress toward treatment goal is being made. This includes review of the diagnosis.

Comparison of Benefit Design to HB 498

Benefit Component	HB 498	SHP Considered Benefit	Explanation of Difference
Diagnosis	"Diagnosed with autism spectrum disorder by a licensed physician, or a licensed psychologist who determines the care to be medically necessary" (G.S. 58-3-192.a.10)	Diagnosis and referral for ABA will only be accepted from an MD, DO, Doctor of Psychology (Psy.D.), or a PhD Psychologist.	Limits diagnosis to licensed physician, Doctor of Psychology or PhD Psychologist.
Providers of Treatment	ABA Provided or supervised by: (i) a Board Certified Behavior Analyst or (ii) a licensed psychologist or licensed psychological associate, so long as the services performed are commensurate with the psychologist's training and experience (G.S. 58-3-192.a.3(b))	Care that the provider cannot legally provide or legally charge or is outside the scope of license or certification is not covered. ABA rendered by a Psychologist with interventions provided by ancillary staff, including paraprofessionals, supervised by the psychologist is covered.	Does not recognize the provision of ABA by BCBAs. ABA falls within the scope of practice of a psychologist and BCBAs are not licensed to provide ABA in North Carolina.

Comparison of Benefit Design to HB 498

Benefit Component	HB 498	SHP Considered Benefit	Explanation of Difference
Board Certified Behavior Analysts	Does not prevent a Board Certified Behavior Analyst (BCBA) or a Board Certified Assistant Behavior Analyst (BCaBA) from offering services within the scope of practice authorized by the Behavior Analyst Certification Board, including behavior analysis and therapy, in accordance with professional standards of the BCBA or BCaBA's certification, if both of the following are true: (1) The BCBA or BCaBA is properly certified and in good standing with the Behavior Analyst Certification Board; and (2) does not hold him/herself out to be a licensed psychologist. (G.S. 90-270.4 f1)	Will only cover ABA provided by licensed providers for whom ABA is within their scope of practice.	Compliant with currently existing NC law.

Comparison of Benefit Design to HB 498

Benefit Component	HB 498	SHP Considered Benefit	Explanation of Difference
Behavioral Health Treatment	Counseling and treatment programs, including applied behavior analysis, that are (a) necessary to i) increase appropriate or adaptive behaviors, ii) decrease maladaptive behaviors, or iii) develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual, and (b) provided or supervised by i) BCBSA or ii) a licensed psychologist or licensed psychological associate, so long as the services performed are commensurate with the psychologist's training and experience. (G.S. 53-3-192)	Expands SHP coverage to include ABA so long as clinical criteria are met. See Value Options clinical criteria for 2.60 Outpatient Services, 2.605 Applied Behavior Analysis. Provider must be licensed and performing within their scope of practice.	Requires additional clinical criteria be met including that certain behaviors are present and less intensive treatment is not sufficient or has been unsuccessful.

Comparison of Benefit Design to HB 498

Benefit Component	HB 498	SHP Considered Benefit	Explanation of Difference
Exclusions	None listed	ABA for individuals: • With medical conditions or impairments that would prevent beneficial utilization of services • Requiring 24 hour medical/nursing monitoring or procedures provided in a hospital setting ABA treatment will not be certified for the following services: • Speech therapy • Occupational therapy • Vocational rehabilitation • Supportive respite care • Recreational therapy • Orientation and mobility • Respite Care • Equine therapy • Hippo therapy • Dolphin therapy • Service Animals • Other educational services	ABA excluded for individuals with an underlying medical condition that would interfere with effectiveness of treatment. Therapies and services that are not evidence based are excluded.

Comparison of Benefit Design to HB 498

Benefit Component	HB 498	SHP Considered Benefit	Explanation of Difference
Therapeutic Care	Therapeutic care. – Direct or consultative services provided by a licensed or certified speech therapist, occupational therapist, physical therapist, or licensed clinical social worker. (G.S. 58-3-192.a.9)	The Plan currently covers therapeutic care.	ABA therapy is recognized as being distinct from other therapies and therefore, therapeutic care provided during ABA therapy is not covered.
Annual benefit maximum	$36,000 annual maximum (G.S. 58-3-192.g)	$36,000 annual maximum	No Change

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

H **4**

HOUSE BILL 498
Committee Substitute Favorable 5/14/13
Committee Substitute #2 Favorable 5/15/13
Fourth Edition Engrossed 5/15/13

Short Title: Autism Health Insurance Coverage. (Public)

Sponsors:

Referred to:

April 3, 2013

1 A BILL TO BE ENTITLED
2 AN ACT TO REQUIRE HEALTH BENEFIT PLANS, INCLUDING THE STATE HEALTH
3 PLAN FOR TEACHERS AND STATE EMPLOYEES, TO PROVIDE COVERAGE FOR
4 THE TREATMENT OF AUTISM SPECTRUM DISORDERS.
5 The General Assembly of North Carolina enacts:
6 **SECTION 1.** Article 3 of Chapter 58 of the General Statutes is amended by adding
7 a new section to read as follows:
8 "**§ 58-3-192. Coverage for autism spectrum disorders.**
9 (a) As used in this section, the following definitions apply:
10 (1) Applied behavior analysis. – The design, implementation, and evaluation of
11 environmental modifications using behavioral stimuli and consequences to
12 produce socially significant improvement in human behavior, including the
13 use of direct observation, measurement, and functional analysis of the
14 relationship between environment and behavior.
15 (2) Autism spectrum disorder. – Any of the pervasive developmental disorders
16 or autism spectrum disorders as defined by the most recent edition of the
17 Diagnostic and Statistical Manual of Mental Disorders (DSM) or the most
18 recent edition of the International Statistical Classification of Diseases and
19 Related Health Problems.
20 (3) Behavioral health treatment. – Counseling and treatment programs,
21 including applied behavior analysis, that are both of the following:
22 a. Necessary to (i) increase appropriate or adaptive behaviors, (ii)
23 decrease maladaptive behaviors, or (iii) develop, maintain, or restore,
24 to the maximum extent practicable, the functioning of an individual.
25 b. Provided or supervised by (i) a Board Certified Behavior Analyst or
26 (ii) a licensed psychologist or licensed psychological associate, so
27 long as the services performed are commensurate with the
28 psychologist's training and experience.
29 (4) Diagnosis of autism spectrum disorder. – Any medically necessary
30 assessments, evaluations, or tests to diagnose whether an individual has
31 autism spectrum disorder.
32 (5) Health benefit plan. – As defined in G.S. 58-3-167, and including the State
33 Health Plan for Teachers and State Employees established under Article 3B
34 of Chapter 135 of the General Statutes.

1 (6) Pharmacy care. – Medications prescribed by a licensed physician and any
2 health-related services deemed medically necessary to determine the need
3 for or effectiveness of the medications.
4 (7) Psychiatric care. – Direct or consultative services provided by a licensed
5 psychiatrist.
6 (8) Psychological care. – Direct or consultative services provided by a licensed
7 psychologist or licensed psychological associate.
8 (9) Therapeutic care. – Direct or consultative services provided by a licensed or
9 certified speech therapist, occupational therapist, physical therapist, or
10 licensed clinical social worker.
11 (10) Treatment for autism spectrum disorders. – Any of the following care or
12 related equipment ordered for an individual diagnosed with autism spectrum
13 disorder by a licensed physician, or a licensed psychologist who determines
14 the care to be medically necessary:
15 a. Behavioral health treatment.
16 b. Pharmacy care.
17 c. Psychiatric care.
18 d. Psychological care.
19 e. Therapeutic care.
20 (b) Every health benefit plan shall provide coverage for the screening, diagnosis, and
21 treatment of autism spectrum disorder for individuals 23 years of age or younger. No insurer
22 shall terminate coverage or refuse to issue, amend, or renew coverage to an individual solely
23 because the individual is diagnosed with autism spectrum disorder or has received treatment for
24 autism spectrum disorder. Individuals must have received a diagnosis of autism spectrum
25 disorder prior to the age of eight to qualify for required coverage under this section.
26 (c) Coverage under this section may not be subject to any limits on the number of visits
27 an individual may have for treatment of autism spectrum disorder.
28 (d) Coverage under this section may not be denied on the basis that the treatments are
29 habilitative or educational in nature.
30 (e) Coverage under this section may be subject to co-payment, deductible, and
31 coinsurance provisions of a health benefit plan that are not less favorable than the co-payment,
32 deductible, and coinsurance provisions that apply to substantially all other medical services
33 covered by the health benefit plan.
34 (f) This section shall not be construed as limiting benefits that are otherwise available
35 to an individual under a health benefit plan.
36 (g) Coverage for behavioral health treatment under this section may be subject to a
37 maximum benefit of up to thirty-six thousand dollars ($36,000) per year.
38 (h) Except for inpatient services, if an individual is receiving treatment for autism
39 spectrum disorder, an insurer shall have the right to request a review of that treatment not more
40 than once annually, unless the insurer and the individual's licensed physician or the individual's
41 licensed psychologist agree that a more frequent review is necessary. Any such agreement
42 regarding the right to review a treatment plan more frequently shall apply only to a particular
43 insured being treated for an autism spectrum disorder and shall not apply to all individuals
44 being treated for an autism spectrum disorder by a physician or psychologist. The cost of
45 obtaining any review shall be borne by the insurer.
46 (i) This section shall not apply to plans that are certified as qualified health plans, as
47 defined in 45 C.F.R. § 155.20, if the requirements of this section are determined by the federal
48 government to require the State to make payments for a state-required benefit that is in excess
49 of the essential health benefits, pursuant to 45 C.F.R. § 155.170(a)(3). Nothing in this
50 subsection shall nullify the application of this section to plans that are not certified as qualified
51 health plans.

(j) This section shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan, an individualized education program, or an individualized service plan.

(k) The Commissioner of Insurance shall grant a health benefit plan issuer a waiver from the provisions of this section for a health benefit plan if the issuer demonstrates to the Commissioner, by actual claims experience over any consecutive 12-month period, that compliance with this section has increased the cost of the health benefit plan by an amount of one percent (1%) or greater in the premium rate charged under the health benefit plan over the most recent calendar year."

SECTION 2. G.S. 90-270.4 is amended by adding a new subsection to read as follows:

"(f1) Nothing in this Article shall be construed to prevent a Board Certified Behavior Analyst (BCBA) or a Board Certified Assistant Behavior Analyst (BCaBA) from offering services within the scope of practice authorized by the Behavior Analyst Certification Board, including behavior analysis and therapy, in accordance with professional standards of the BCBA or BCaBA's certification, if both of the following are true:

(1) The BCBA or BCaBA is properly certified and in good standing with the Behavior Analyst Certification Board.

(2) The BCBA or BCaBA does not hold himself or herself out to the public by any title or description stating or implying that the BCBA or BCaBA is a psychologist or is licensed, certified, or registered to practice psychology in this State."

SECTION 3.(a) G.S. 135-48.51 reads as rewritten:

"**§ 135-48.51. Coverage and operational mandates related to Chapter 58 of the General Statutes.**

The following provisions of Chapter 58 of the General Statutes apply to the State Health Plan:

(1) G.S. 58-3-191, Managed care reporting and disclosure requirements.

(2) G.S. 58-3-192, Coverage for autism spectrum disorders.

~~(2)~~(3) G.S. 58-3-221, Access to nonformulary and restricted access prescription drugs.

~~(3)~~(4) G.S. 58-3-223, Managed care access to specialist care.

~~(4)~~(5) G.S. 58-3-225, Prompt claim payments under health benefit plans.

~~(5)~~(6) G.S. 58-3-235, Selection of specialist as primary care provider.

~~(6)~~(7) G.S. 58-3-240, Direct access to pediatrician for minors.

~~(7)~~(8) G.S. 58-3-245, Provider directories.

~~(8)~~(9) G.S. 58-3-250, Payment obligations for covered services.

~~(9)~~(10) G.S. 58-3-265, Payment obligations for covered services.

~~(10)~~(11) G.S. 58-3-280, Coverage for the diagnosis and treatment of lymphedema.

~~(11)~~(12) G.S. 58-3-285, Coverage for hearing aids.

~~(12)~~(13) G.S. 58-50-30, Right to choose services of optometrist, podiatrist, licensed clinical social worker, certified substance abuse professional, licensed professional counselor, dentist, physical therapist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor, advanced practice nurse, licensed marriage and family therapist, or physician assistant.

~~(13)~~(14) G.S. 58-67-88, Continuity of care."

SECTION 3.(b) No later than March 1, 2015, and every March 1st thereafter, the Department of the State Treasurer shall submit a report to the General Assembly regarding the

1 implementation of coverage under the State Health Plan for Teachers and State Employees
2 required under this section. The report shall include the following information:
3 (1) The total number of insureds diagnosed with autism spectrum disorder.
4 (2) The total costs of all claims paid out in the prior fiscal year for coverage
5 required by this section.
6 (3) The cost of coverage required under this section per insured per month.
7 (4) The average cost per insured for coverage of any treatment involving applied
8 behavior analysis.
9 **SECTION 4.** Section 1 of this act becomes effective October 1, 2013, and applies
10 to insurance contracts issued, renewed, or amended on or after that date. Section 3 of this act
11 becomes effective January 1, 2014. The remainder of this act is effective when it becomes law.

CPT® Category III Codes

The following CPT codes are an excerpt of the CPT Category III code set, a temporary set of codes for emerging technologies, services, and procedures.

For more information on the criteria for CPT Category I, II and III codes, see Applying for Codes.

To assist users in reporting the most recently approved Category III codes, the AMA's CPT Web site features updates of the CPT Editorial Panel actions and early release of the Category III codes in July and January in a given CPT cycle. This was approved by the CPT Editorial Panel as a part of the 1998-2000 CPT-5 projects. These dates for early release correspond with the three annual CPT Editorial Panel meetings for each CPT cycle (June, October, and February). Although publication of Category III codes through early release to the CPT web site allows for expedient dispersal of the code and descriptor, early availability does not imply that these codes are immediately reportable before the posted implementation date.

Publication of the Category III codes to this Web site takes place on a semiannual basis when the codes have been approved by the CPT Editorial Panel. The full set of temporary Category III codes for emerging technology, procedures and services are published annually in the code set for each CPT publication cycle.

As with CPT Category I codes, inclusion of a descriptor and its associated code number does not represent endorsement by the AMA of any particular diagnostic or therapeutic procedure or service. Inclusion or exclusion of a procedure or service does not imply any health insurance coverage or reimbursement policy.

Background information for Category III codes
CPT Category III codes are a set of temporary codes that allow data collection for emerging technology, services, and procedures. These codes are intended to be used for data collection to substantiate widespread usage or to provide documentation for the Food and Drug Administration (FDA) approval process. The CPT Category III codes may not conform to the following CPT Category I code requirements:

- All devices and drugs necessary for performance of the procedure or service have received FDA clearance or approval when such is required for performance of the procedure or service.
- The procedure or service is performed by many physicians or other qualified health care professionals across the United States.
- The procedure or service is performed with frequency consistent with the intended clinical use (ie, a service for a common condition should have high volume, whereas a service commonly performed for a rare condition may have low volume).
- The procedure or service is consistent with current medical practice.
- The clinical efficacy of the procedure or service is documented in literature that meets the requirements set forth in the CPT code change application.

These codes have an alpha character as the 5th character in the string preceded by four digits (e.g., 1234T) and are located in a separate section of the CPT codebook, following the Medicine section. The introductory language for this code section explains the purpose of these codes

CPT Category III codes are intended to be used for data collection purposes to substantiate widespread usage or to provide documentation for the FDA approval process. Category III codes are not developed as a result of Panel review of an incomplete proposal, the need for more information, or a lack of CPT

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Advisory Committee support of a code change application.

CPT Category III codes are not referred to the AMA-Specialty RVS Update Committee (RUC) for valuation because no relative value units (RVUs) are assigned to these codes. Payment for these services or procedures is based on the policies of payers and not on a yearly fee schedule.

In general, a given Category III code will be archived five years from the date of initial publication or extension unless a modification of the archival date is specifically noted at the time of a revision or change to a code (eg, addition of parenthetical instructions, reinstatement).

Category III codes for CPT 2015

It is important to note that, because future CPT Editorial Panel or Executive Committee actions may affect these items, codes and descriptor language may differ at the time of publication. Also, future Panel actions may result in gaps in code number sequencing. A cross-reference will appear in the Category III section of the CPT codebook to direct users to the newly established CPT Category I code.

Unless otherwise indicated, the symbol ● indicates new procedure codes that will be added to the CPT codebook in 2015.

Category III codes

The following section contains a set of temporary codes for emerging technology, services, and procedures. Category III codes allow data collection for these services or procedures. Use of unlisted codes does not offer the opportunity for the collection of specific data. If a Category III code is available, this code must be reported instead of a Category I unlisted code. This is an activity that is critically important in the evaluation of health care delivery and the formation of public and private policy. The use of the codes in this section allows physicians and other qualified health care professionals, insurers, health services researchers, and health policy experts to identify emerging technology, services, and procedures for clinical efficacy, utilization, and outcomes.

The inclusion of a service or procedure in this section neither implies nor endorses clinical efficacy, safety, or the applicability to clinical practice. The codes in this section may not conform to the usual requirements for CPT Category I codes established by the Editorial Panel. The nature of emerging technology, services, and procedures is such that the requirements for the Category I criteria may not be met. For these reasons, temporary codes for emerging technology, services, and procedures have been placed in a separate section of the CPT codebook, and the codes are differentiated from CPT Category I codes by the use of the alphanumeric characters.

Services/procedures described in this section make use of alphanumeric characters. These codes have an alpha character as the 5th character in the string (ie, four digits followed by the letter T). The digits are not intended to reflect the placement of the code in the Category I section of CPT nomenclature. Codes in this section may or may not eventually receive a Category I CPT code. In either case, in general, a given Category III code will be archived five years from the date of initial publication or extension unless a modification of the archival date is specifically noted at the time of a revision or change to a code (eg, addition of parenthetical instructions, reinstatement). Services/procedures described by Category III codes which have been archived after five years, without conversion, must be reported using the Category I unlisted code unless another specific cross reference is established at the time of archiving.
New codes or revised codes are released semi-annually via the AMA/CPT internet site, to expedite dissemination for reporting. The full set of temporary codes for emerging technology, services, and procedures are published annually in the CPT codebook. Go to www.ama-assn.org/go/cpt for the most current listing.

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Category III codes 0340T- 0346T were accepted at the May 2013 CPT Editorial Panel meeting for the 2015 CPT production cycle. Therefore, these codes do not appear in the 2014 CPT codebook. However, due to the Category III code early release policy, these codes are effective on January 1, 2014, following the six- month implementation period which began on July 1, 2013. Shaded text refers to additional refinements accepted at the October 2013 CPT Editorial Panel meeting for the 2015 CPT production cycle.		
⊙●0340T Ablation, pulmonary tumor(s), including pleura or chest wall when involved by tumor extension, percutaneous, cryoablation, unilateral, includes imaging guidance	Released July 1, 2013 Implemented January 1, 2014 Moderate Sedation symbol ⊙ added October 2013	***CPT 2015***
(Do not report code 0340T in conjunction with 76940, 77013, 77022)		
●0341T Quantitative pupillometry with interpretation and report, unilateral or bilateral	Released July 1, 2013 Implemented January 1, 2014	***CPT 2015***
●0342T Therapeutic apheresis with selective HDL delipidation and plasma reinfusion	Released July 1, 2013 Implemented January 1, 2014	***CPT 2015***
●0343T Transcatheter mitral valve repair percutaneous approach including transseptal puncture when performed; initial prosthesis	Released July 1, 2013 Implemented January 1, 2014	***CPT 2015***
●0344T additional prosthesis (es) during same session (List separately in addition to code for primary procedure)	Released July 1, 2013 Implemented January 1, 2014	***CPT 2015***
(Use 0343T in conjunction with 0344T)		
●0345T Transcatheter mitral valve repair percutaneous approach via the coronary sinus	Released July 1, 2013 Implemented January 1, 2014	***CPT 2015***
(0343T is applicable for initial prosthesis placed during a session even when patient has an existing mitral valve prosthesis in place)		

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	(Do not report 0343T, 0344T, 0345T in conjunction with 93451, 93452, 93453, 93456, 93457, 93458, 93459, 93460, 93461for diagnostic left and right heart catheterization procedures intrinsic to the valve repair procedure)		
	(Do not report 0345T in conjunction with 93453, 93454 for coronary angiography intrinsic to the valve repair procedure)		
●0346T	Ultrasound, elastography (List separately in addition to code for primary procedure)	Released July 1, 2013 Implemented January 1, 2014	***CPT 2015***
	(Use 0346T in conjunction with 76536, 76604, 76645, 76700, 76705, 76770, 76775, 76830, 76856, 76857, 76870, 76872, 76881, 76882)		
	(For elastography without ultrasound imaging, use an unlisted code)	Refinement approved October 2013	
Category III codes were accepted at the October 2013 CPT Editorial Panel meeting for the 2015 CPT production cycle. However, due to the Category III code early release policy, these codes are effective on July 1, 2014, following the six-month implementation period which begins January 1, 2014.			
●0347T	Placement of interstitial device(s) in bone for radiostereometric analysis (RSA)	Released January 1, 2014 Implemented July 1, 2014	***CPT 2015***
●0348T	Radiologic examination, radiostereometric analysis (RSA); spine, (includes, cervical, thoracic and lumbosacral, when performed)	Released January 1, 2014 Implemented July 1, 2014	***CPT 2015***
●0349T	upper extremity(ies), (includes shoulder, elbow and wrist, when performed)	Released January 1, 2014 Implemented July 1, 2014	***CPT 2015***

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●0350T	lower extremity(ies), (includes hip, proximal femur, knee and ankle, when performed)	Released January 1, 2014 Implemented July 1, 2014	***CPT 2015***
●0351T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; real time intraoperative	Released January 1, 2014 Implemented July 1, 2014	***CPT 2015***
●0352T	interpretation and report, real time or referred	Released January 1, 2014 Implemented July 1, 2014	
	(Do not report 0352T in conjunction with 0351T when performed by the same physician)		
●0353T	Optical coherence tomography of breast, surgical cavity; real time intraoperative	Released January 1, 2014 Implemented July 1, 2014	***CPT 2015***
	(Report 0353T once per session)		
●0354T	interpretation and report, real time or referred	Released January 1, 2014 Implemented July 1, 2014	***CPT 2015***
	(Do not report 0354T in conjunction with 0353T when performed by the same physician)		
●0355T	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report	Released January 1, 2014 Implemented July 1, 2014	***CPT 2015***
	(Use 0355T for imaging of distal ileum, when performed)		
	(Do not report 0355T in conjunction with 91110, 91111)		
●0356T	Insertion of drug-eluting implant (including punctual dilation and implant removal when performed) into lacrimal canaliculus, each	Released January 1, 2014 Implemented July 1, 2014	***CPT 2015***

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Code	Descriptor	Status	Publication
●0358T Bioelectrical impedance analysis whole body composition assessment, supine position, with interpretation and report		Released January 1, 2014 Implemented July 1, 2014	***CPT* 2015**
Adaptive Behavior Assessments ***Behavior identification assessment (0359T)*** conducted by the physician or other qualified health care professional, includes a detailed behavioral history, patient observation, administration of standardized and non-standardized tests and structured guardian/caregiver interview to identify and describe deficient adaptive or maladaptive behaviors (eg, impaired social skills and communication deficits, destructive behaviors, and additional functional limitations secondary to maladaptive behaviors). 0359T also includes the physician's or other qualified health care professional's interpretation of results and development of plan of care, which may include further observational or exposure behavioral follow-up assessment(s) (0360T, 0361T, 0362T, 0363T), discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report. ***Observational behavioral follow-up assessment (0360T, 0361T)*** is administered by a technician under the direction of a physician or other qualified health care professional. The physician or other qualified health care professional may or may not be on-site during the face-to-face assessment process. Codes 0360T, 0361T include the physician's or other qualified health care professional's interpretation of results, discussion of findings and recommendations with the primary caregiver(s), and preparation of report. Codes 0360T, 0361T describe services provided to patients who present with specific destructive behavior(s) (eg, self-injurious behavior, aggression, property destruction) or behavioral problems secondary to repetitive behaviors or deficits in communication or social relatedness. These assessments include use of structured observation and/or standardized and non-standardized tests to determine levels of adaptive behavior. Areas assessed may include cooperation, motivation, visual understanding, receptive and expressive language, imitation, requests, labeling, play and leisure and social interactions. Specific destructive behavior(s) assessments include structured observational testing to examine events, cues, responses, and consequences associated with the behavior(s).			***CPT* 2015**

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Exposure behavioral follow-up assessment (0362T, 0363T) is administered by the physician or other qualified health care professional with the assistance of one or more technicians. Codes 0362T, 0363T include the physician's or other qualified health care professional's interpretation of results, discussion of findings and recommendations with the primary caregiver(s), and preparation of report. The typical patients for 0362T, 0363T include patients with one or more specific severe destructive behavior(s) (eg, self-injurious behavior, aggression, property destruction). Specific severe destructive behavior(s) are assessed using structured testing to examine events, cues, responses, and consequences associated with the behavior(s).		
Codes 0362T, 0363T include exposing the patient to a series of social and environmental conditions associated with the destructive behavior(s). Assessment methods include using testing methods designed to examine triggers, events, cues, responses, and consequences, associated with the before mentioned maladaptive behavior(s). This assessment is completed in a structured, safe environment. Codes 0360T, 0361T, 0362T, 0363T are reported following 0359T based on the time that the patient is face-to-face with one or more technician(s). Only count the time of one technician when two or more are present. Codes 0360T, 0361T, 0362T, 0363T are reported per the CPT Time Rule (eg, a unit of time is attained when the mid-point is passed). See Table 1. The time reported with 0360T, 0361T, 0362T, 0363T is over a single day and is not cumulative over a longer period. Do not report 0359T, 0360T, 0361T, 0362T, 0363T in conjunction with 90785-90899, 96101-96125, 96150, 96151, 96152, 96153, 96154, 96155 on the same date. (For psychiatric diagnostic evaluation, see 90791, 90792) (For speech evaluations, use 92506) (For occupational therapy evaluation, see 97003, 97004) (For medical team conference, see 99366, 99367, 99368) (For health and behavior assessment/intervention, see 96150, 96151, 96152, 96153, 96154, 96155) (For neurobehavioral status exam, use 96116) (For neuropsychological testing, use 96118)		

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Table1
Reporting of 0360T, 0361T, 0362T, 0363T per CPT Time Rule
Utilizing Face-to-Face Technician Time

Less than 16 min	Not reportable
16 – 45 min	0360T or 0362T
46 – 75 min	0360T and 0361T, or 0362T and 0363T
Each additional increment up to 30 min	Additional 0361T or 0363T

Code	Descriptor	Status	Publication
●0359T	Behavior identification assessment, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report	Released January 1, 2014 Implemented July 1, 2014	***CPT 2015***
●0360T	Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-to-face with the patient	Released January 1, 2014 Implemented July 1, 2014	***CPT 2015***
✚●0361T	each additional 30 minutes of technician time, face-to-face with the patient (List separately in addition to code for primary service)	Released January 1, 2014 Implemented July 1, 2014	***CPT 2015***
	(Use 0361T in conjunction with 0360T)		
●0362T	Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; first 30 minutes of technician(s) time, face-to-face with the patient	Released January 1, 2014 Implemented July 1, 2014	***CPT 2015***

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✚●0363T each additional 30 minutes of technician(s) time, face-to-face with the patient (List separately in addition to code for primary procedure)	Released January 1, 2014 Implemented July 1, 2014	***CPT 2015***
(Use 0363T in conjunction with 0362T)		
(0362T, 0363T are reported based on a single technician's face-to-face time with the patient and not the combined time of multiple technicians)		
Do not report 0359T, 0360T, 0361T, 0362T, 0363T in conjunction with 90785-90899, 96101-96125, 96150, 96151, 96152, 96153, 96154, 96155)		
Coding Tip If the physician or other qualified health care professional personally performs the technician activities, his or her time engaged in these activities may be included as part of the required technician time to meet the elements of the code.		
Adaptive Behavior Treatment Adaptive behavior treatment codes 0364T-0374T describe services provided to patients, presenting with deficient adaptive or maladaptive behaviors (eg, impaired social skills and communication, destructive behaviors, or additional functional limitations secondary to maladaptive behaviors). Specific target problems and treatment goals are based on results of previous assessments (see 0359T-0363T).	Released March 2014 Implemented July 1, 2014	***CPT 2015***
Adaptive behavior treatment by protocol and group adaptive behavior treatment by protocol are administered by a technician face-to-face with one patient (0364T, 0365T), or two or more patients (0366T, 0367T) under the direction of a physician or other qualified health care professional, utilizing a behavior intervention protocol designed in advance by the physician or other qualified health care professional who may or may not provide direct supervision during the face-to-face therapy. Do not report 0366T, 0367T if the group is larger than 8 patients.		

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Adaptive behavior treatment with protocol modification (0368T, 0369T) is administered by a physician or other qualified health care professional face-to-face with a single patient The physician or other qualified health care professional resolves one or more problems with the protocol and may simultaneously instruct a technician and/or guardian(s)/caregiver(s) in administering the modified protocol. Physician or other qualified health care professional instruction of the technician without the patient present is not reported separately.		
Family adaptive behavior treatment guidance and multiple-family group adaptive behavior treatment guidance are administered by a physician or other qualified health care professional face-to-face with guardian(s)/caregiver(s), without the presence of a patient, and involves identifying problem behaviors and deficits and teaching guardian(s)/caregiver(s) of one patient (0370T) or multiple patients (0371T) to utilize treatment protocols designed to reduce maladaptive behaviors and/or skill deficits. Do not report 0371T if the group is larger than 8 patients.		
Adaptive behavior treatment social skills group (0372T) is administered by a physician or other qualified health care professional face-to-face with multiple patients, focusing on social skills training and identifying and targeting individual patient social deficits and problem behaviors. The physician or other qualified health care professional monitors the needs of individual patients and adjusts the therapeutic techniques during the group, as needed. Services to increase target social skills may include modeling, rehearsing, corrective feedback, and homework assignments. In contrast to adaptive behavior treatment by protocol techniques (0364T-0367T), adjustments required in social skills group setting are made in real time rather than for a subsequent service. Do not report 0372T if the group is larger than 8 patients.		
Codes 0364T-0369T, 0372T may include services involving patient interaction with other individuals, including other patients. Report group services (0366T, 0367T, 0372T) only for patients who are participating in the interaction in order to meet their own individual treatment goals.		
Coding Tips If the physician or other qualified health care professional personally performs the technician activities, his or her time engaged in these activities may be reported as technician time. Each minute is only counted once whether 1 or more than one treating individual is present		

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●0364T	**Adaptive behavior treatment by protocol**, administered by technician, face-to-face with one patient; first 30 minutes of technician time	Released March 2014 Implemented July 1, 2014	***CPT 2015***
✚●0365T	each additional 30 minutes of technician time (List separately in addition to code for primary procedure)	Released March 2014 Implemented July 1, 2014	***CPT 2015***
	(Use 0365T in conjunction with 0364T)		
	(Do not report 0364T, 0365T in conjunction with 90785-90899, 92507, 96101-96155, 97532)		
●0366T	Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time	Released March 2014 Implemented July 1, 2014	***CPT 2015***
✚●0367T	each additional 30 minutes of technician time (List separately in addition to code for primary procedure)	Released March 2014 Implemented July 1, 2014	***CPT 2015***
	(Use 0367T in conjunction with 0366T)		
	(Do not report 0366T, 0367T if the group is larger than 8 patients)		
	(Do not report 0366T, 0367T in conjunction with 90785-90899, 92508, 96101-96155, 97150)		
●0368T	Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; first 30 minutes of patient face-to-face time	Released March 2014 Implemented July 1, 2014	***CPT 2015***
●0369T	each additional 30 minutes of patient face-to-face time (List separately in addition to code for primary procedure)	Released March 2014 Implemented July 1, 2014	***CPT 2015***

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	(Use 0369T in conjunction with 0368T)		
	(Do not report 0368T, 0369T in conjunction with 90791, 90792, 90846, 90847, 90887, 92507, 97532)		
●0370T	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)	Released March 2014 Implemented July 1, 2014	***CPT 2015***
●0371T	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)	Released March 2014 Implemented July 1, 2014	***CPT 2015***
	(Do not report 0371T when the families of more than 8 patients are participants)		
	(Do not report 0370T, 0371T in conjunction with 90791, 90792, 90846, 90847, 90887)		
●0372T	Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face-to-face with multiple patients	Released March 2014 Implemented July 1, 2014	***CPT 2015***
	(Do not report 0372T if the group is larger than 8)		
	(Do not report 0372T in conjunction with 90853, 92508, 97150)		

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Exposure Adaptive Behavior Treatment With Protocol Modification Codes 0373T, 0374T describe services provided to patients with one or more specific severe destructive behaviors (eg, self-injurious behavior, aggression, property destruction), with direct supervision by a physician or other qualified health care professional which requires two or more technicians face-to-face with the patient for safe treatment. Technicians elicit behavioral effects of exposing the patient to specific environmental conditions and treatments. Technicians record all occurrences of targeted behaviors. The physician or other qualified health care professional reviews and analyzes data and refines the therapy using single-case designs; ineffective components are modified or replaced until discharge goals are achieved (eg, reducing destructive behavior by at least 90%, generalizing the treatment effects across caregivers and settings, or maintaining the treatment effects over time). The therapy is conducted in a structured, safe environment. Precautions may include environmental modifications and/or protective equipment for the safety of the patient or the technicians.	Released March 2014 Implemented July 1, 2014	***CPT 2015***
●0373T Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians' time, face-to-face with patient	Released March 2014 Implemented July 1, 2014	***CPT 2015***
✚●0374T each additional 30 minutes of technicians' time face-to-face with patient (List separately in addition to code for primary procedure)	Released March 2014 Implemented July 1, 2014	***CPT 2015***
(Use 0374T in conjunction with 0373T)		
(0373T, 0374T are reported based on a single technician’s face-to-face time with the patient and not the combined time of multiple technicians)		
(Do not report 0373T, 0374T in conjunction with 90785-90899, 96101-96155)		

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HCPC	BSBS NJ Definition	VO Definition	VO Codes	AMA Interim Codes	AMA Interim Codes Definition
H2019	Therapeutic Behavioral Services ABA Follow-up per 15 min	Therapeutic Behavioral Services (direct care), 15 min	**H2019–** HM	0364T +0365T	**-** Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; first 30 minutes of technician time - each additional 30 minutes of technician time (List separately in addition to code for primary procedure)
			H2019- HP, HO HN AH	0368T +0369T	- Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; first 30 minutes of patient face-to-face time - each additional 30 minutes of patient face-to-face time (List separately in addition to code for primary procedure)
			NA	0373T +0374T	- Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians' time, face-to-face with patient - each additional 30 minutes of technicians' time face-to-face with patient (List separately in addition to code for primary procedure)
H2014	NA	Skills training and Development (Social skills group), 15 min	**H2014-** HP HO HN AH	0372T	- Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face-to-face with multiple patients
			H2014- HM	0366T +0367T	- Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time - each additional 30 minutes of technician time (List separately in addition to code for primary procedure)
H0031	Mental Health Assessment by non-physician ABA Reassessment per 15 min	Mental health assessment by non-physician per hr	**H0031-** HP HO HN AH	***0359T***	*Behavior identification assessment conducted by physician or other qualified health care professional*
H0032	Mental health service plan by non-physician ABA Initial Assessment and Plan Development per hr	Mental health service plan development by non-physician, per hr	**NA**	***0360T*** ***+0361T***	*Observational behavioral follow-up assessment by technician under direction of physician/QHCP (16 – 45 min)* *Observational behavioral follow-up assessment by technician under direction of physician/QHCP (46 – 75 min w **0361T**)*
			H0032- HP HO HN AH	***0362T*** ***+0363T***	*Exposure behavioral follow-up assessment by physician or other qualified health care professional (16 – 45 min)* *Exposure behavioral follow-up assessment by physician or other qualified health care professional (46 – 75 min w **0361T***)
S5110	NA	Home care training, family, 15 min	**S5110-** HP HO HN AH	0370T	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)
			NA	0371T	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)
H0046	Mental health services, NOS (Supervision of ABA follow-up per 15 min	**NA**	NA	NA	NA

G9012	NA	Other specified case management services not elsewhere classified (case consultation with larger care team)	**G9012-** HP HO HN AH	NA	NA
S5108	NA	Home care training to home care client (supervision of direct care provider - Higher Level Supervisor), 15 min	**S5108-** HP HO HN AH	NA	NA

Behavior identification assessment (0359T) conducted by the physician or other qualified health care professional, includes a detailed behavioral history, patient observation, administration of standardized and non-standardized tests and structured guardian/caregiver interview to identify and describe deficient adaptive or maladaptive behaviors (eg, impaired social skills and communication deficits, destructive behaviors, and additional functional limitations secondary to maladaptive behaviors). 0359T also includes the physician's or other qualified health care professional's interpretation of results and development of plan of care, which may include further observational or exposure behavioral follow-up assessment(s) (0360T, 0361T, 0362T, 0363T), discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report.

Observational behavioral follow-up assessment (0360T, 0361T) is administered by a technician under the direction of a physician or other qualified health care professional. The physician or other qualified health care professional may or may not be on-site during the face-to-face assessment process. Codes 0360T, 0361T include the physician's or other qualified health care professional's interpretation of results, discussion of findings and recommendations with the primary caregiver(s), and preparation of report.
Codes 0360T, 0361T describe services provided to patients who present with specific destructive behavior(s) (eg, self-injurious behavior, aggression, property destruction) or behavioral problems secondary to repetitive behaviors or deficits in communication or social relatedness. These assessments include use of structured observation and/or standardized and non-standardized tests to determine levels of adaptive behavior. Areas assessed may include cooperation, motivation, visual understanding, receptive and expressive language, imitation, requests, labeling, play and leisure and social interactions. Specific destructive behavior(s) assessments include structured observational testing to examine events, cues, responses, and consequences associated with the behavior(s).

Exposure behavioral follow-up assessment (0362T, 0363T) is administered by the physician or other qualified health care professional with the assistance of one or more technicians. Codes 0362T, 0363T include the physician's or other qualified health care professional's interpretation of results, discussion of findings and recommendations with the primary caregiver(s), and preparation of report.
The typical patients for 0362T, 0363T include patients with one or more specific severe destructive behavior(s) (eg, self-injurious behavior, aggression, property destruction). Specific severe destructive behavior(s) are assessed using structured testing to examine events, cues, responses, and consequences associated with the behavior(s).

Codes 0362T, 0363T include exposing the patient to a series of social and environmental conditions associated with the destructive behavior(s). Assessment methods include using testing methods designed to examine triggers, events, cues, responses, and consequences, associated with the before mentioned maladaptive behavior(s). This assessment is completed in a structured, safe environment.
Codes 0360T, 0361T, 0362T, 0363T are reported following 0359T based on the time that the patient is face-to-face with one or more technician(s). Only count the time of one technician when two or more are present. Codes 0360T, 0361T, 0362T, 0363T are reported per the CPT Time Rule (eg, a unit of time is attained when the mid-point is passed). See Table 1. The time reported with 0360T, 0361T, 0362T, 0363T is over a single day and is not cumulative over a longer period.

Less than 16 min	Not reportable
16-45 min	0360T or 0362T
46-75 min	0360T and 0361T; or 0362T and 0363T
Each additional increment up to 30 min	Additional 0361T or 0363T

0359T Behavior identification assessment, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report	Released January 1, 2014 Implemented July 1, 2014	***CPT 2015***
●0360T Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-to-face with the patient	Released January 1, 2014 Implemented July 1, 2014	***CPT 2015***
✚●0361T each additional 30 minutes of technician time, face-to-face with the patient (List separately in addition to code for primary service)	Released January 1, 2014 Implemented July 1, 2014	***CPT 2015***
(Use 0361T in conjunction with 0360T)		
●0362T Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; first 30 minutes of technician(s) time, face-to-face with the patient	Released January 1, 2014 Implemented July 1, 2014	***CPT 2015***

✚●0363T each additional 30 minutes of technician(s) time, face-to-face with the patient (List separately in addition to code for primary procedure)	Released January 1, 2014 Implemented July 1, 2014	***CPT 2015***
(Use 0363T in conjunction with 0362T)		
(0362T, 0363T are reported based on a single technician's face-to-face time with the patient and not the combined time of multiple technicians)		
Do not report 0359T, 0360T, 0361T, 0362T, 0363T in conjunction with 90785-90899, 96101-96125, 96150, 96151, 96152, 96153, 96154, 96155)		
Coding Tip If the physician or other qualified health care professional personally performs the technician activities, his or her time engaged in these activities may be included as part of the required technician time to meet the elements of the code.		

Adaptive Behavior Treatment Adaptive behavior treatment codes 0364T-0374T describe services provided to patients, presenting with deficient adaptive or maladaptive behaviors (eg, impaired social skills and communication, destructive behaviors, or additional functional limitations secondary to maladaptive behaviors). Specific target problems and treatment goals are based on results of previous assessments (see 0359T-0363T).	Released March 2014 Implemented July 1, 2014	***CPT 2015***

Adaptive behavior treatment by protocol and group adaptive behavior treatment by protocol are administered by a technician face-to-face with one patient (0364T, 0365T), or two or more patients (0366T, 0367T) under the direction of a physician or other qualified health care professional, utilizing a behavior intervention protocol designed in advance by the physician or other qualified health care professional who may or may not provide direct supervision during the face-to-face therapy. Do not report 0366T, 0367T if the group is larger than 8 patients.

Adaptive behavior treatment with protocol modification (0368T, 0369T) is administered by a physician or other qualified health care professional face-to-face with a single patient The physician or other qualified health care professional resolves one or more problems with the protocol and may simultaneously instruct a technician and/or guardian(s)/caregiver(s) in administering the modified protocol. Physician or other qualified health care professional instruction of the technician without the patient present is not reported separately.

Family adaptive behavior treatment guidance and multiple-family group adaptive behavior treatment guidance are administered by a physician or other qualified health care professional face-to-face with guardian(s)/caregiver(s), without the presence of a patient, and involves identifying problem behaviors and deficits and teaching guardian(s)/caregiver(s) of one patient (0370T) or multiple patients (0371T) to utilize treatment protocols designed to reduce maladaptive behaviors and/or skill deficits. Do not report 0371T if the group is larger than 8 patients.

Adaptive behavior treatment social skills group (0372T) is administered by a physician or other qualified health care professional face-to-face with multiple patients, focusing on social skills training and identifying and targeting individual patient social deficits and problem behaviors. The physician or other qualified health care professional monitors the needs of individual patients and adjusts the therapeutic techniques during the group, as needed. Services to increase target social skills may include modeling, rehearsing, corrective feedback, and homework assignments. In contrast to adaptive behavior treatment by protocol techniques (0364T-0367T), adjustments required in social skills group setting are made in real time rather than for a subsequent service. Do not report 0372T if the group is larger than 8 patients.

Codes 0364T-0369T, 0372T may include services involving patient interaction with other individuals, including other patients. Report group services (0366T, 0367T, 0372T) only for patients who are participating in the interaction in order to meet their own individual treatment goals.

Coding Tips

If the physician or other qualified health care professional personally performs the technician activities, his or her time engaged in these activities may be reported as technician time. Each minute is only counted once whether 1 or more than one treating individual is present

●0364T **Adaptive behavior treatment by protocol**, administered by technician, face-to-face with one patient; first 30 minutes of technician time	Released March 2014 Implemented July 1, 2014	***CPT 2015***
✚●0365T each additional 30 minutes of technician time (List separately in addition to code for primary procedure)	Released March 2014 Implemented July 1, 2014	***CPT 2015***
(Use 0365T in conjunction with 0364T)		

(Do not report 0364T, 0365T in conjunction with 90785-90899, 92507, 96101-96155, 97532)		
●0366T Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time	Released March 2014 Implemented July 1, 2014	***CPT 2015***
✚●0367T each additional 30 minutes of technician time (List separately in addition to code for primary procedure)	Released March 2014 Implemented July 1, 2014	***CPT 2015***
(Use 0367T in conjunction with 0366T)		
(Do not report 0366T, 0367T if the group is larger than 8 patients)		
(Do not report 0366T, 0367T in conjunction with 90785-90899, 92508, 96101-96155, 97150)		
●0368T Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; first 30 minutes of patient face-to-face time	Released March 2014 Implemented July 1, 2014	***CPT 2015***
●0369T each additional 30 minutes of patient face-to-face time (List separately in addition to code for primary procedure)	Released March 2014 Implemented July 1, 2014	***CPT 2015***
(Use 0369T in conjunction with 0368T)		
(Do not report 0368T, 0369T in conjunction with 90791, 90792, 90846, 90847, 90887, 92507, 97532)		
●0370T Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)	Released March 2014 Implemented July 1, 2014	***CPT 2015***
●0371T Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)	Released March 2014 Implemented July 1, 2014	***CPT 2015***
(Do not report 0371T when the families of more than 8 patients are participants)		
(Do not report 0370T, 0371T in conjunction with 90791, 90792, 90846, 90847, 90887)		
●0372T Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face-to-face with multiple patients	Released March 2014 Implemented July 1, 2014	***CPT 2015***
(Do not report 0372T if the group is larger than 8)		
(Do not report 0372T in conjunction with 90853, 92508, 97150)		
Exposure Adaptive Behavior Treatment With Protocol Modification Codes 0373T, 0374T describe services provided to patients with one or more specific severe destructive behaviors (eg, self-injurious behavior, aggression, property destruction), with direct supervision by a physician or other qualified health care professional which requires two or more technicians face-to-face with the patient for safe treatment. Technicians elicit behavioral effects of exposing the patient to specific environmental conditions and treatments. Technicians record all occurrences of targeted behaviors. The physician or other qualified health care professional reviews and analyzes data and refines the therapy using single-case designs; ineffective components are modified or replaced until discharge goals are achieved (eg, reducing destructive behavior by at least 90%, generalizing the treatment effects across caregivers and settings, or maintaining the treatment effects over time). The therapy is conducted in a structured, safe environment. Precautions may include environmental modifications and/or protective	Released March 2014 Implemented July 1, 2014	***CPT 2015***

equipment for the safety of the patient or the technicians.		
●0373T Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians' time, face-to-face with patient	Released March 2014 Implemented July 1, 2014	***CPT 2015***
✚●0374T each additional 30 minutes of technicians' time face-to-face with patient (List separately in addition to code for primary procedure)	Released March 2014 Implemented July 1, 2014	***CPT 2015***
(Use 0374T in conjunction with 0373T)		
(0373T, 0374T are reported based on a single technician's face-to-face time with the patient and not the combined time of multiple technicians)		
(Do not report 0373T, 0374T in conjunction with 90785-90899, 96101-96155)		

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Analysis of the Evidence Base for ABA and EIBI for Autism

Eric V. Larsson, Ph.D., L.P., B.C.B.A.-D. (2012)

A misimpression stands that the treatment of autism lacks evidence-based approaches. However, in actuality, Applied Behavior Analysis (ABA) and Early Intensive Behavioral Intervention (EIBI) are possibly the best examples of evidence-based behavioral health care. In contrast to the folklore that one hears, independent reviews consistently agree that ABA and EIBI treatments for autism are effective, and that the extensive body of research meets high standards of evidence.

Two such independent reviews are highlighted here.

One well-known review was conducted for Division 53 of the American Psychological Association (the Society for Clinical Child and Adolescent Psychology). The following was concluded:

> *"Randomized controlled trials have demonstrated positive effects in both short-term and longer term studies. The evidence suggests that early intervention programs are indeed beneficial for children with autism, often improving developmental functioning and decreasing maladaptive behaviors and symptom severity at the level of group analysis." (Page 8).*

> *"Lovaas's treatment meet Chambless and colleague's (Chambless et al., 1998; Chambless et al., 1996) criteria for 'well-established'" (Page 8).*

> *"Across all the studies we cited, improvements in language, communication, and IQ, and reduction in severity of autism symptoms indicate that the core symptoms of autism appear malleable in early childhood"* (page 30).

> Rogers, S.J., & Vismara, L.A. (2008). Evidence-based comprehensive treatments for early autism. *Journal of Clinical Child and Adolescent Psychology*. 37, 8-38.

In another review, the state of Hawaii convened a Department of Health Task Force to identify evidence-based treatments in children's mental health. The overarching goals of the task force were to broaden and update the summary of scientific information used to guide decisions about children's care. The report provides an extensive review of the major randomized, controlled research findings for psychosocial treatments for children. The committee grouped its findings into "treatment families" of similar treatments for given disorders and represented these on a "Blue Menu" summary.

Regarding the treatment of autism, the "Hawaii Blue Menu" report stated:

> *"Two treatment families demonstrated Best Support. Intensive Behavioral Treatment was successful in three (3) studies, beating alternative treatments in two (2) of those, and beating a no-treatment control in one (1). Likewise, Intensive Communication Training was*

also successful in three (3) studies, beating alternative treatments in two (2) of those, and beating a no-treatment control in one (1) study." (Page 16).

"These results are quite promising in terms of effect size, although it should be noted that the outcome variables for these studies mainly involved reductions in the frequency of —autistic behaviors or increases in social communication or other forms of social exchange (e.g., turn taking). None of these studies claimed that children were —autism free following the intervention programs. Nevertheless, these findings represent an extraordinary improvement over the evidence base for interventions for autistic spectrum disorders in the previous Biennial Report." (Page 18).

"The shape of the profile suggests that all successful treatments for autistic spectrum disorders involve teaching communication skills and modeling of appropriate communication or other behaviors. Other strategies include training in non-verbal communication (social skills), teaching parents and teachers to praise desired behaviors, and the setting of goals paired with the intensive rehearsal and reinforcement of behaviors consistent with those goals (i.e., discrete trial training)." (Page 19).

Chorpita, B.F. & Daleiden, E.L. (2007). *2007 Biennial report: Effective psychosocial interventions for youth with behavioral and emotional needs.* Child and Adolescent Mental Health Division, Honolulu: Hawaii Department of Health.

Here are two other statements from recent objective scientific reviews of EIBI.

"Recovery in children with ASD through behavioral and educational interventions seems possible in a significant minority of cases." (page 360).

Helt, M., Kelley, E., Kinsbourne, M., Pandey, J., Boorstein, H., Herbert, M., & Fein, D. (2008). Can children with autism recover? If so, how? *Neuropsychology Review.* 18, 339-366. (The authors are psychologists and pediatricians at the University of Connecticut, Queen's University, the New School, Children's Hospital of Philadelphia, and Massachusetts General Hospital).

"The weight of currently available scientific evidence, however, indicates that ABA should be viewed as the optimal, comprehensive treatment approach in young children with ASD."

Barbaresi, W.J., Katusic, S.K., & Voigt, R.G. (2006). Autism: A review of the state of the science for pediatric primary health care clinicians. *Archives of Pediatric and Adolescent Medicine*, 160. 1167-1175. (The authors are pediatricians at the Mayo Clinic and at Harvard University).

Forty-five such independent, meta-analysis, and peer reviews are listed in a bibliography below. In none of these do the authors systematically refute the published evidence for ABA treatments of autism. The reviews are critical evaluations – in many cases, other non-ABA treatments are assigned to categories such as "insufficient evidence," "unproven," or even "potentially harmful."

Yet every review cites the obvious positive results of ABA and EIBI and accepts them as proven. The most "negative" conclusions that are offered are:

1) ABA does not cure all children of autism
2) ABA is not the only established treatment, nor is it clearly the best treatment
3) There are not well-established means to identify the best candidates for treatment

It should be noted that the above conclusions can be drawn about any medical treatment that already enjoys full coverage, so they should not be cause for denying coverage for ABA.

However, the lay impression persists that there are "negative" reviews in the literature. But let's look at what the "negative" reviews do say. The following is the *most skeptical* recent publication in the scientific literature. But see one of their concluding statements.

> *"There is little question now that early intensive behavioral intervention is highly effective for some children. However, gains are not universal, and some children make only modest progress while others show little or no change, sometimes after extremely lengthy periods in treatment."* (page 36).

Howlin, P., Magiati, I., & Charman, T. (2009). Systematic review of early intensive behavioral interventions for children with autism. *American Journal on Intellectual and Developmental Disabilities*. 114. 23-41. (The authors are professors at the Institute of Psychiatry, King's College (London, UK) and University College, London, Institute of Child Health).

Other "negative" reviews may exclude the majority of ABA research, by applying highly restrictive criteria for what qualifies as evidence.

For example, there is the Comparative Effectiveness Review published by the AHRQ in 2011. But, while this report has also been cited as "negative," see their main conclusions regarding ABA and EIBI interventions.

> *"Evidence supports early intensive behavioral and developmental intervention, including the University of California, Los Angeles (UCLA)/Lovaas model and Early Start Denver Model (ESDM) for improving cognitive performance, language skills, and adaptive behavior in some groups of children."* (page vi).

> *"Evidence suggests that interventions focusing on providing parent training and cognitive behavioral therapy (CBT) for bolstering social skills and managing challenging behaviors may be useful for children with ASDs to improve social communication, language use, and potentially, symptom severity.* (page vi).

The "negative" qualifiers of these conclusions are stated as:

> *"All of these studies need to be replicated, and specific focus is needed to characterize which children are most likely to benefit."* (page vi).

> *"Information is lacking on modifiers of effectiveness, generalization of effects outside the treatment context, components of multicomponent therapies that drive effectiveness, and predictors of treatment success."* (page vi).

In comparison to the above comments, these are the clearly negative conclusions about traditional biomedical treatments that are currently widely covered by insurance policies:

> *"No current medical interventions demonstrate clear benefit for social or communication symptoms in ASDs."* (page vi).

> *"Little evidence is available to assess other behavioral interventions, allied health therapies, or complementary and alternative medicine."* (page vi).

Warren, Z., Veenstra-VanderWeele, J., Stone, W., Bruzek, J.L., Nahmias, A.S., Foss-Feig, J.H., Jerome, R.N., Krishnaswami, S., Sathe, N.A., Glasser, A.M., Surawicz, T., & McPheeters, M.L. (April, 2011). Therapies for Children With Autism Spectrum Disorders. *Comparative Effectiveness Review No. 26*. (Prepared by the Vanderbilt Evidence-based Practice Center under Contract No.290-2007-10065-I.) AHRQ Publication No. 11-EHC029-EF. Rockville, MD:Agency for Healthcare Research and Quality. Available at: www.effectivehealthcare.ahrq.gov/reports/final.cfm.

The AHRQ report reached these positive conclusions about ABA and EIBI despite excluding a large number of studies, including all studies published prior to 2000. Yet the AHRQ report still found 78 studies of behavioral interventions, which included 34 studies of EIBI that met their criteria for inclusion.

Other "negative" reviews cited are typically proprietary reports published privately. For example, the Kaiser Blue Cross report did not offer positive statements (Rothenberg & Samson, 2009). However in their methodology, they limited their analysis to only 16 studies, out of the hundreds available, and concluded that more research needs to be done. Interestingly, unlike the AHRQ review, this report did not comment on the comparable lack of data for psychotropic medications, yet insurance companies readily cover such treatment.

Three other areas of research, that were not addressed by the AHRQ report or the proprietary reports, are the following: cost-benefit analyses, meta-analyses of effect magnitude, and direct analyses of significant behavior improvement. Here are some sample conclusions from these fields of research.

Cost-Benefit Analyses

> *"Under our model parameters, expansion of IBI to all eligible children represents a cost-saving policy whereby total costs of care for autistic individuals are lower and gains in dependency-free life years are higher.* (page 136).

> Motiwala, S.S., Gupta, S., Lilly, M.D., Ungar, W.J., & Coyte, P.C. (2006). The cost-effectiveness of expanding intensive behavioural intervention to all autistic children in Ontario. *Healthcare Policy*, 1, 135-151.. (The authors are members of the Department of Health Policy, Management and Evaluation of the University of Toronto, ON).

Meta-Analyses of Magnitude of Effect

> *"Results suggested that long-term, comprehensive ABA intervention leads to (positive) medium to large effects in terms of intellectual functioning, language development, acquisition of daily living skills and social functioning in children with autism. Although favorable effects were apparent across all outcomes, language-related outcomes (IQ, receptive and expressive language, communication) were superior to non-verbal IQ, social functioning and daily living skills, with effect sizes approaching 1.5 for receptive and expressive language and communication skills. Dose-dependant effect sizes were apparent by levels of total treatment hours for language and adaptation composite scores."* (page 387).

> Virues-Ortega, J. (2010). Applied behavior analytic intervention for autism in early childhood: Meta-analysis, meta-regression and dose–response meta-analysis of multiple outcomes. *Clinical Psychology Review.* 30, 387-399. (The author is a professor of psychology at the University of Manitoba).

Analyses of the Direct Effect of ABA on Clinically Significant Behavior Disorders

> *"The available intervention technology is reasonably effective at reducing problem behaviors performed by people with developmental disabilities, including autism. Reductions of 80% or greater were reported in half to two thirds of the comparisons. Reductions of 90% or greater were reported for all classes of problem behavior, and with individuals with all diagnostic labels."* (page 429).

> Horner, R.H., Carr, E.G., Strain, P.S., Todd, A.W., & Reed, H.K. (2002). Problem behavior interventions for young children with autism: A research synthesis. *Journal of Autism and Developmental Disorders.* 32, 423-446. (The authors are professors at the University of Oregon, the State University of New York at Stony Brook, and the University of Colorado).

"Within the last 8 years, 66 studies with strong or acceptable methodological rigor have been conducted and published. These studies have been conducted using over 500 participants, and have evaluated interventions with different delivery agents, methods, target skills, and settings. Collectively, the results of this synthesis show there is much supporting evidence for the treatment of social deficits in autism." (page 161).

Reichow, B. & Volkmar, F.R. (2010). Social Skills Interventions for Individuals with Autism: Evaluation for Evidence-Based Practices within a Best Evidence Synthesis Framework. *Journal of Autism and Developmental Disorders.* 40, 149-166. (The authors are professors at the Yale University Child Study Center, New Haven, CT).

Earnest researchers and clinicians welcome the challenge to even further extend the effectiveness of ABA to more children, and are continuing to innovate to do so. But it is clear that all professional circles now agree that there is generous and sufficient evidence to endorse public and private coverage of accountable ABA treatment and Early Intensive Behavioral Intervention.

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NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES

POTENTIAL AUTISM SPECTRUM DISORDER BENEFIT

Prepared by:

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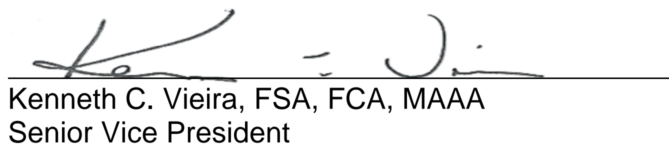
May 2014

ACTUARIAL STATEMENT

The North Carolina State Health Plan for Teachers and State Employees has requested that The Segal Company prepare an Actuarial Note in response to a draft proposal to Provide Coverage for a Potential Autism Spectrum Disorder Benefit.

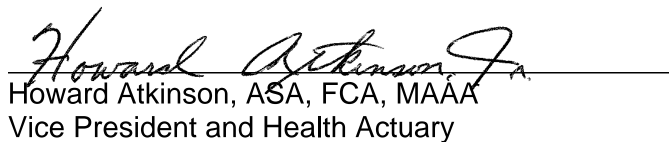
This Actuarial Note was prepared according to generally accepted actuarial principles and practices. The Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and their Claims Processing Contractor.



May 28, 2014
Date

Kenneth C. Vieira, FSA, FCA, MAAA
Senior Vice President



May 28, 2014
Date

Howard Atkinson, ASA, FCA, MAAA
Vice President and Health Actuary

POTENTIAL AUTISM SPECTRUM DISORDER BENEFIT

PLAN CHANGES

The State Health Plan Board of Trustees is considering providing coverage for the treatment of autism spectrum disorders.

The full text of the potential benefit is attached to this actuarial note.

PROJECTED COSTS

Option	Plan Design Change	Projected Cost Impact (in Millions) Calendar Year				
		2015	2016	2017	2018	2019
1	Coverage for Autism Spectrum Disorders – $36,000 annual maximum	$4.0	$5.0	$5.2	$5.5	$5.8
2	Coverage for Autism Spectrum Disorders – no annual maximum	$5.7	$7.8	$8.6	$9.8	$10.9

PRICING APPROACH AND COMMENTS

The following information was compiled and utilized in determining the projected costs or savings of each benefit component addressed in this actuarial note:

- In total, 32 states have autism mandates in place as of January 2013.

- According to the Centers for Disease Control (CDC) Autism and Developmental Disabilities Monitoring (ADDM) Network, the prevalence of autism spectrum disorders in 2010 was one in 68 children at the age of eight. The CDC states that most individuals are diagnosed with an autism disorder by this age. This number has been increasing over time as diagnosis become more common and practice patterns evolve.

Year	Prevalence Per 1,000	1 in x Children
2000	6.7	1 in 150
2002	6.6	1 in 150
2004	8.0	1 in 125
2006	9.0	1 in 110
2008	11.3	1 in 88
2010	14.7	1 in 68

Over the 8 year period the prevalence has grown from 6.7% to 14.7%, or approximately 10% per year. Due to large increase the last two years, we have assumed a slower growth of 5% per year.

- Very little mature insured data exists for use in developing credible utilization and unit cost estimates for Applied Behavioral Analysis (ABA). While the ultimate cost of covering ABA benefits is uncertain, our analysis reflects the likely behavior of consumers and providers of ABA services in developing the assumptions underlying the cost estimates.

- ABA may include 30-40 hours of therapy a week, though it is unlikely many programs would utilize that level of resources.

- ABA programs require a significant commitment from affected children, as well as their families. It is likely that a significant number of ASD children will not have an ABA program regardless of the availability of a provider.

- The North Carolina State Health Plan (the Plan) currently covers medical benefits for autism spectrum disorder, including medical visits, physical therapy, occupational therapy, speech therapy and psychological testing. ABA and other behavioral therapies are typically considered "educational therapy" and presently not a component of the Plan's medical benefit. ABA is defined as "the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior".

- A Blue Cross and Blue Shield of North Carolina (BCBSNC) report was provided showing the number of members diagnosed with autism spectrum disorders and other pervasive developmental disorders as well as each member's claim expenditures for the Plan for the Fiscal Years 2010, 2011, 2012 and through March Fiscal Year 2013. Based on reported autism diagnosis codes, the BCBSNC report identified 728 plan members, 619 members under age 21, with paid claims in Fiscal Year 2013. These member counts by age are shown below.

Number of Members Diagnosed with Autistic Spectrum Disorder in Plan

Age	Members
Under 6	80
6	26
7	37
8	34
9	44
10	55
11	45
12	50
13 to 20	248
21 and Over	109
Total	728

- In Minnesota, a state that is widely regarded as having some of the most extensive ABA coverage and services in the nation, provider data indicates ABA utilization of approximately 20% of diagnosed three to six year olds (taken from a March 2012 Oliver Wyman report in discussion with Dr. Eric Larsson Executive Director, Clinical Services, The Lavaas Institute for Early Intervention. Midwest Headquarters regarding ABA utilization research in Minnesota. February 2009.)

- According to the Wyman study, in addition to the likelihood of starting a program, program continuance assumptions have a very significant impact on overall ABA utilization and cost estimates. ABA programs are generally geared towards addressing deficits in younger children and are not intended to be continued indefinitely. For this reason, we have assumed that no programs would terminate prior to school age, that a large percentage of ABA programs would terminate at ages six and seven, when an autistic child could be expected to enter elementary school, and annually thereafter a large percentage of remaining programs would terminate until only a very small percentage of children have ABA programs by the time they reach their teenage years. From the Wyman study, the assumed percentage of children diagnosed with ASD that have an ABA program by age is shown in the table below:

% of Diagnosed Children with Autistic Disorder with ABA

Age	%
Under 6	65.0%
6	48.8%
7	32.5%
8	21.7%
9	14.4%
10	9.6%
11	6.4%
12	4.3%
13 to 21	3.3%

We have assumed the ABA prevalence for those ages 21-26 would also remain at the 3.3% level.

- In developing the assumed annual ABA program hours, we discussed typical ABA programming with ABA providers, and received benefit materials from one of the large self-insured employers who offers ABA benefits (Autism Therapy Reference – Microsoft Corporation (administered by Premera Blue Cross))

Average Annual ABA Program Hours for a Child with Autism Disorder

Ages	Hours
Ages Under 8	1500
Ages 8 to 12	671
Ages 13 to 21	401

We have assumed the ABA programs hours would remain for 401 for those at 21-26.

- Based on information reported by the Families for Early Autism Treatment (FEAT) of North Carolina, treatment cost ranges from $25 - $60 per hour. We assume $60 per hour in our analysis.

- Assuming a $30 copay applies to each three-hour session (3 hours @ $60/hour = $180), we reduced the developed cost by approximately 17% to account for this design feature.

- We do not make any adjustment to the utilization data to account for therapies and services that are deemed to be excluded because they are not evidence based.

Fiscal Impact

- Utilizing the assumptions above we expect 132 members to utilize ABA services in Calendar 2015. This is expected to grow to 161 by Calendar Year 2019.

- Based on the expected utilization and associated ABA cost figures, we estimate the fiscal impact of adding ABA services to the Plan to be approximately $4.0 million for calendar year 2015 assuming a January 1, 2015 effective date, a two-month claims payment lag and a $36,000 annual maximum. This amount grows to $5.7 million for calendar year 2015 if the annual maximum is eliminated.

- A 25% margin was added to the unlimited benefit option to cover the uncertainty and open-ended nature of the benefit.

Comparison of Benefit Design to HB 498

Benefit Component	HB 498	SHP Considered Benefit	Explanation of Difference
Age requirements	Diagnosis: Prior to Age 8 Treatment: Age 23 (G.S. 58-3-192.b)	Diagnosis and Treatment up to Age 26	Age changed to match dependent eligibility
Utilization management	An insurer shall have the right to request a review of that treatment not more than once annually, unless the insurer and the individual's licensed physician or the individual's licensed psychologist agree that a more frequent review is necessary. Any such agreement regarding the right to review a treatment plan more frequently shall apply only to a particular insured being treated for an autism spectrum disorder and shall not apply to all individuals being treated for an autism spectrum disorder by a physician or psychologist. The cost of obtaining any review shall be borne by the insurer. (G.S. 58-3-192.h)	Consistent with SHP utilization management policies through BCBSNC and Value Options. Prior authorization will be required for the initial treatment plan as well as all continuing treatment.	Prior authorization for both initial and continuing treatment is necessary to ensure that therapy is appropriate for the individual and that progress toward treatment goal is being made. This includes review of the diagnosis.

Comparison of Benefit Design to HB 498

Benefit Component	HB 498	SHP Considered Benefit	Explanation of Difference
Diagnosis	"Diagnosed with autism spectrum disorder by a licensed physician, or a licensed psychologist who determines the care to be medically necessary" (G.S. 58-3-192.a.10)	Diagnosis and referral for ABA will only be accepted from an MD, DO, Doctor of Psychology (Psy.D.), or a PhD Psychologist.	Limits diagnosis to licensed physician, Doctor of Psychology or PhD Psychologist.
Providers of Treatment	ABA Provided or supervised by: (i) a Board Certified Behavior Analyst or (ii) a licensed psychologist or licensed psychological associate, so long as the services performed are commensurate with the psychologist's training and experience (G.S. 58-3-192.a.3(b))	Care that the provider cannot legally provide or legally charge or is outside the scope of license or certification is not covered. ABA rendered by a Psychologist with interventions provided by ancillary staff, including paraprofessionals, supervised by the psychologist is covered.	Does not recognize the provision of ABA by BCBAs. ABA falls within the scope of practice of a psychologist and BCBAs are not licensed to provide ABA in North Carolina.

Comparison of Benefit Design to HB 498

Benefit Component	HB 498	SHP Considered Benefit	Explanation of Difference
Board Certified Behavior Analysts	Does not prevent a Board Certified Behavior Analyst (BCBA) or a Board Certified Assistant Behavior Analyst (BCaBA) from offering services within the scope of practice authorized by the Behavior Analyst Certification Board, including behavior analysis and therapy, in accordance with professional standards of the BCBA or BCaBA's certification, if both of the following are true: (1) The BCBA or BCaBA is properly certified and in good standing with the Behavior Analyst Certification Board; and (2) does not hold him/herself out to be a licensed psychologist. (G.S. 90-270.4 f1)	Will only cover ABA provided by licensed providers for whom ABA is within their scope of practice.	Compliant with currently existing NC law.

Comparison of Benefit Design to HB 498

Benefit Component	HB 498	SHP Considered Benefit	Explanation of Difference
Behavioral Health Treatment	Counseling and treatment programs, including applied behavior analysis, that are (a) necessary to i) increase appropriate or adaptive behaviors, ii) decrease maladaptive behaviors, or iii) develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual, and (b) provided or supervised by i) BCBSA or ii) a licensed psychologist or licensed psychological associate, so long as the services performed are commensurate with the psychologist's training and experience. (G.S. 53-3-192)	Expands SHP coverage to include ABA so long as clinical criteria are met. See Value Options clinical criteria for 2.60 Outpatient Services, 2.605 Applied Behavior Analysis. Provider must be licensed and performing within their scope of practice.	Requires additional clinical criteria be met including that certain behaviors are present and less intensive treatment is not sufficient or has been unsuccessful.

Comparison of Benefit Design to HB 498

Benefit Component	HB 498	SHP Considered Benefit	Explanation of Difference
Exclusions	None listed	ABA for individuals: • With medical conditions or impairments that would prevent beneficial utilization of services • Requiring 24 hour medical/nursing monitoring or procedures provided in a hospital setting ABA treatment will not be certified for the following services: • Speech therapy • Occupational therapy • Vocational rehabilitation • Supportive respite care • Recreational therapy • Orientation and mobility • Respite Care • Equine therapy • Hippo therapy • Dolphin therapy • Service Animals • Other educational services	ABA excluded for individuals with an underlying medical condition that would interfere with effectiveness of treatment. Therapies and services that are not evidence based are excluded.

Comparison of Benefit Design to HB 498

Benefit Component	HB 498	SHP Considered Benefit	Explanation of Difference
Therapeutic Care	Therapeutic care. – Direct or consultative services provided by a licensed or certified speech therapist, occupational therapist, physical therapist, or licensed clinical social worker. (G.S. 58-3-192.a.9)	The Plan currently covers therapeutic care.	ABA therapy is recognized as being distinct from other therapies and therefore, therapeutic care provided during ABA therapy is not covered.
Annual Benefit Maximum	$36,000 annual maximum (G.S. 58-3-192.g)	$36,000 annual maximum	No Change

Applied Behavior Analyst (ABA)
Credentialing Criteria

Board Certified Behavior Analyst Doctoral (BCBA-D)*

a) Doctoral degree, conferred at least ten (10) years prior to applying with a specialty of behavior analysis, psychology, education or another related field **and**

b) A minimum of 10 years post-doctoral experience in behavior analysis **and**

c) Certified as a Board Certified Behavior Analyst – Doctoral (BCBA-D) by the Behavior Analyst Certification Board.

d) State Licensed to practice at the highest level of independent practice in the state where practice is to occur (if applicable).

e) Possess professional liability coverage at a minimum level of $1,000,000 per episode and $1,000,000 aggregate except where state or client requirements are more stringent.

Board Certified Behavior Analyst (BCBA)*

a) Master's degree or higher from a graduate school with a specialty of behavior analysis, psychology, special education or related field **and**

b) A minimum of 12 credit hours of graduate level course work in behavioral analysis; courses must have focus on application of behavior analysis, rather than more generic topics in the discipline for which the graduate degree was awarded. The courses should address the following issues in applied behavior analysis; family dynamics, ethical considerations, definition and characteristics, principles, processes and concepts; behavioral assessment and the selection of intervention strategies and outcomes; experimental evaluation of interventions; measurement of behavior and displaying/interpreting behavioral data; behavioral change procedures and systems support (Adapted from the Behavior Analyst Certification Board) **and**

c) A minimum of six months full-time supervised employment (or internship/Practicum in behavior analysis under the supervision of a behavior analysis)

d) Certified as a Behavior Analyst (**BCBA**) by the Behavior Analyst Certification Board.

e) State Licensed to practice at the highest level of independent practice in the state where practice is to occur (if applicable).

f) All provider applicants must have a minimum of one (1) year post certification experience providing direct patient care

g) Possess professional liability coverage at a minimum level of $1,000,000 per episode and $1,000,000 aggregate except where state or client requirements are more stringent.

Applied Behavior Analyst (ABA)
Credentialing Criteria

Board Certified Assistant/Associate Behavior Analyst (BCaBA)*

a) Bachelor's degree or higher with coursework in behavior analysis, including ethical considerations, definition and characteristics, principles, processes and concepts; behavioral assessment and the selection of intervention strategies and outcomes; experimental evaluation of interventions; measurement of behavior and displaying/interpreting behavioral data; behavioral change procedures and systems support. (Adapted from the Behavior Analyst Certification Board)

b) A minimum of 1000 hours of Supervised Independent Fieldwork in behavior analysis conducting assessment activities related to the need for behavioral interventions, Designing, implementing, and monitoring behavior analysis programs for clients, and Overseeing the implementation of behavior analysis programs by others. (Adapted from the Behavior Analyst Certification Board)

c) Certified as an Assistant Behavior Analyst (**BCaBA**) by the Behavior Analyst Certification Board.

d) May only provide patient care services under the direction and supervision of a Master's level Certified Behavior Analyst (BCBA). Must report the name of their BCBA supervisor(s) and provide documentation of that supervision as requested.

e) All provider applicants must have a minimum of one (1) year post certification experience providing direct patient care.

f) Possess professional liability coverage at a minimum level of $1,000,000 per episode and $1,000,000 aggregate except where state or client requirements are more stringent.

**(Applies Only to States/Client Accounts where required by regulation or benefit plan)*

2.60 OUTPATIENT SERVICES

2.605 Applied Behavioral Analysis (ABA)

Description of Services:

When covered by the benefit plan or state mandate, ValueOptions provides utilization care management for Applied Behavioral Analysis (ABA) which may be classified as an educational rehabilitation service, a medical benefit, or a behavioral benefit depending on the benefit plan. ABA is a systematic and structured strategy for addressing challenging behavior problems often found in individuals with Autism Spectrum Disorders (ASD). Such challenging behavioral problems are culturally abnormal behaviors of such an intensity, frequency or duration that the physical safety of the individual or others is likely threatened, or, behavior which is likely to seriously limit the ability to participate in common social activities such as the educational system and in addition the individual may be denied access to, ordinary community facilities. The ABA approach relies on applying experimentally derived principles of behaviorism to modify behavior.

ABA begins with an initial behavioral assessment of the individual with ASD in order to determine skills that are either present or absent in the individual's behavioral repertoire. Selection of treatment goals follows using data from the initial assessment. The treatment plan includes skills in all domains (acquiring learning skills, communication, social, academic, self-care, motor, play and leisure, etc.). The treatment program itself entails using intensive teaching techniques carefully designed to reinforce appropriate social behaviors in children with ASD. Typically, the ABA program consists of discrete trials where the "therapist" issues a directive to the patient, receives a response from the patient, and then there is a reaction from the "therapist" in order to either positively or negatively reinforce the patient's behavioral response.

The individual ABA treatment plan is developed by a professional with advanced formal training and certification in behavioral analysis, and this level of professional directs the program. The actual 1:1 sessions are typically provided by behavioral technicians or paraprofessionals for up to 40 hours of patient contact per week in a variety of settings (school; home; community). The technician is supervised by the ABA certified professional.

ABA is an extremely intensive treatment program. It can occur in any number of settings, including school, home, agencies, hospitals, etc. It is imperative that the interventions be applied systematically and uniformly, and that behavioral data is gathered, maintained and analyzed in order to evaluate the effectiveness of both the treatment plan and the interventions. Licensure and credentialing requirements specific to facilities and individual practitioners do apply and are found in our provider manual/credentialing information

Criteria	
Admission Criteria	***All** of the following criteria are necessary for admission*: 1. The individual demonstrates behavioral symptoms consistent with a DSM-IV-TR (or most current DSM), (Axes I-V) diagnosis falling within the range of Autism Spectrum Disorders (299.00, 299.10, 299.80) 2. The individual displays a "severe challenging behavior" that either 1) presents a health or safety risk to self or others (e.g., self-injury, aggressive behaviors, destruction of property severe disruptive behaviors) or 2) significantly interferes with socially acceptable activities in the home or community due to the objectionable nature of the

	behavior, 3. Less intensive forms of behavioral treatment or therapy have not been sufficient or are not appropriate to reduce the interfering behaviors, increase pro-social behaviors, or to maintain desired behaviors. 4. There is a reasonable expectation on the part of a qualified treating health professional who has evaluated the individual that the behavior will improve or the individual will receive maximum benefit through the use of Applied Behavioral Analysis. 5. The treatment plan is individualized: objectives are measurable and tailored to the individual. Interventions emphasize generalization of skill and focus on the development of spontaneous social communication, adaptive skills and appropriate behaviors and include a focus that: • Is child centered, strengths based, family inclusive, community based, culturally competent, and provided in the least restrictive setting • Targets specific behaviors (including frequency, rate, symptom intensity, duration). • Incorporates objective baseline and quantifiable progress measures. • Describes detailed behavioral interventions, reinforcers, strategies for generalization of skills beyond the ABA sessions. • Coordinates ancillary services and transition plans. 6. Parent/caregiver training and support is included into the treatment plan with documented plans that skills transfer to the parent/caregiver will occur.
Psychosocial, Occupational, and Cultural and Linguistic Factors	*These factors, as detailed in the Introduction, may change the risk assessment and should be considered when making level of care decisions.*
Exclusion Criteria	***Any** of the following criteria are sufficient for exclusion from this level of care*: 1. The individual has medical conditions or impairments that would prevent beneficial utilization of services. 2. The individual requires the 24-hour medical/nursing monitoring or procedures provided in a hospital setting. 3. ABA treatment will not be certified for the following services: a. Speech therapy b. Occupational therapy c. Vocational rehabilitation d. Supportive respite care e. Recreational therapy f. Orientation and mobility g. Respite care h. Equine therapy

	i. Hippo therapy j. Dolphin therapy k. Other educational services
Continuing Stay Criteria	***All** of the following criteria are necessary for continuing treatment at this level of care*: 1. The individual's condition continues to meet admission criteria for Applied Behavioral Analysis, either due to continuation of presenting problems, or appearance of new problems or symptoms. 2. There is reasonable expectation that the individual will benefit from the continuation of ABA services. 3. Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated. The treatment plan is updated based on treatment progress including the addition of new target behaviors. 4. All services and treatment interventions are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice. Expected benefit from all relevant modalities is documented. 5. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms or there are clear benefits to treatment, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident. 6. There is documented skills transfer to the individual and treatment transition planning from the beginning of treatment. 7. There is a documented active attempt at coordination of care with relevant providers/caretakers, etc., when appropriate. If coordination is not successful, the reason(s) are documented 8. Unless contraindicated, family and/or significant other are actively involved in the treatment as required by the treatment plan, or there are active efforts being made and documented to involve them.
Discharge Criteria	***Any** of the following criteria are sufficient for discharge from this level of care*: 1. The individual has achieved adequate stabilization of the challenging behavior and less-intensive modes of treatment are appropriate and indicated. 2. The individual no longer meets admission criteria, or meets criteria for a less or more intensive services. 3. Treatment is making the symptoms persistently worse. 4. The individual is not making progress toward treatment goals, as demonstrated by the absence of any documented meaningful (i.e., durable and generalized) measurable improvement or stabilization of challenging behavior and there is no reasonable expectation of progress.

SCREENING for AUTISM SPECTRUM DISORDER:
(American Academy of Pediatrics)

The American Academy of Pediatrics (AAP) recommends that developmental surveillance should be done at every well – child appointment using an **A.L.A.R.M.** approach:

Autism is prevalent.
Listen to parents about developmental concerns.
Act early with the use of screening.
Refer to appropriate professionals, organizations and programs such as Early Intervention.
Monitor incoming information and the child and family.

During these well-child visits, the primary care clinician should;

- elicit a developmental history,
- listen to parental concerns,
- observe the child directly,
- use developmental checklists to record milestones, and
- decide whether a developmental screening might need to be performed due to developmental concerns about language, social and pretend-play skills.

Note that while parental concerns are often present in the first years of life, the *lack* of parental concern does not imply that a child's development is typical.

Detecting developmental delays early is challenging because children develop and acquire skills asynchronously.

Screening Tools: It is imperative to use screening tools with good reliability, sensitivity, and specificity. Current screening tools may **not** identify children with milder variants of autism, those without mental retardation or language delay, those with Asperger's disorder, or ASD in older children, adolescents, and young adults. Primary care physicians should be familiar with at least one of these tools to be used with children suspected to have an ASD. Recommended screening tools include:

Summary of Selected Assessment Instruments for Autism Spectrum Disorder* From AACAP 2014

Scale (see legend)	Uses	Age Range	Method of Administration	Population Studied	Scale characteristics	Reference
ABC	screening	children	parent rated	AD	57 items, scale 1-4	Krug et al., 198043
CARS	screening	children	clinician rated	AD	15 items, scale 1-4	Schopler et al., 198044
M-CHAT	screening	toddlers	parent rated	AD	23 items, yes/no	Robins et al., 200145
CSBS-DP-IT-Checklist	screening	toddlers	parent rated	AD	24 items	Wetherby et al., 200846
ASQ	screening	child/adult	parent rated	AD/AspD	40 items, yes/no	Berument et al., 199947
AQ	screening	child/adult	self or parent rated	AspD	50 items, scale 0-3	Baron-Cohen et al., 200148
CAST	screening	4-11 years	parent rated	AspD	37 items, yes/no	Scott et al., 200249
ASDS	screening	5-18 years	parent or teacher rated	AspD	50 items, yes/no	Myles et al., 200050
GADS	screening	3-22 years	parent or teacher rated	AspD	32 items, scale 0-3	Gilliam, 200151
ASDI	screening	child/adult	interview + clinician rated	AspD	50 items, yes/no	Gillberg et al., 200152
SRS	screening	4-18 years	parent or teacher rated	AspD	65 items, scale 1-4	Constantino et al., 200353
ADI	diagnostic	child/adult	interview + clinician rated	AD/AspD	see text	Lord et al., 200354
DISCO	diagnostic	child/adult	interview + clinician rated	AD/AspD	see text	Wing et al., 200255
ADOS	diagnostic	child/adult	semi-structured interactive session	AD/AspD	see text	Lord et al., 199456

Note:
ABC = Autism Behavior Checklist;
AD = autism disorder;
ADI = Autism Diagnostic Interview Revised **(See Attachment 1 for a summary of components.)**
ADOS = Autism Diagnostic Observation Schedule;
AQ = Autism Quotient;
ASDI = Asperger Syndrome Diagnostic Interview;
ASDS = Asperger Syndrome Diagnostic Scale;
AspD = Asperger's disorder;
ASQ = Autism Screening Questionnaire;
CARS = Childhood Autism Rating Scale;
AST = Childhood Autism Screening Test;
M-CHAT = Checklist for Autism in Toddlers;
CSBS-DP-IT-Checklist = Communication and Symbolic Behavior Scales Developmental Profile Infant-Toddler Checklist;
DISCO = Diagnostic Interview for Social and Communication Disorders;
GADS = Gilliam Asperger's Disorder Scale;
Parent = primary caregiver;
SRS = Social Responsiveness Scales.

*Note that these instruments may need to be revised to provide evidence of validity for DSM-5 ASD and supplement but DO NOT REPLACE clinical diagnosis. (See Attachment 2 for DSM-5 ASD criteria.)

ATTACHMENT 1:
Autism Diagnostic Interview™, Revised (ADI™-R)
By Michael Rutter, MD, FRS, Ann LeCouteur, MBBS, et al.

http://www.wpspublish.com/store/p/2645/autism-diagnostic-interview-revised-adi-r

Summary of components of the Autism Diagnostic Interview – Revised (ADI-R). *This standardized interview requires extensive training to administer, but is considered the "gold standard" of accuracy in autism screening, so the following summary is provided to allow clinicians to incorporate elements of this instrument into their clinical evaluation.* The questions in the ADI-R are asked of parents/caregivers.

Qualitative Impairment in Social Interactions
- Direct gaze: *Does the child look at you directly in the face while talking to you*?
- Social smiling: *Does the child smile in meeting? In response to others*?
- Showing and directing attention: *Does the child show/bring things*?
- Offering to share: *Food, toys, favorite objects*?
- Seeking to share enjoyment with others: *Does the child direct attention to things (he) likes?*
- Offer comfort: *Spontaneously?*
- Quality of social overtures: *Coordinated eye gaze – pointing*?
- Range of facial expressions used to communicate: *Full range*?
- Inappropriate facial expression: *Related to context*?
- Appropriateness of social responses: *Responses to the approaches of others*?
- Imaginative play: *Pretend games*?
- Imaginative social play: *Initiates and responds to simple social games*?
- Interest in other children: *Interested in children (he) doesn't know*?
- Response to approaches of other children: *Responsive?*
- Group play with peers: *Actively seeks and plays cooperatively*?
- Friendships: *Does (he) have a particular friends or a best friend*?

Qualitative Impairment in Communication
- Use of another's body to communicate: *Uses others as a tool*?
- Age of first single words: *Under 24 months; phrases under 33 months*
- Social vocalizations/chat: *Small talk*?
- Stereotyped utterances and delayed echolalia: *Saying the same thing over and over.*
- Reciprocal conversation: *Able to carry on a conversation*?
- Inappropriate questions or statements: *Seems to lack the understanding of the social impact of questions or statements*?
- Pronomial reversals: *Mixing up you/I/he/she and inappropriate inflection*.
- Neologisms/idiosyncratic language: *Made up words*.
- Verbal rituals: *Insisting on saying or others saying the same thing the same way*
- Spontaneous imitation
- Pointing to express interest: *Uses conventional/instrumental gestures*?
- Nodding: *Nodding to mean yes or shaking head to mean no*.

Restricted, Repetitive and Stereotyped Patterns of Behavior, Interests and Activities
- Circumscribed interests: Unusual in intensity and causing social impairment
- Unusual preoccupations: E.g. metal objects, traffic lights, street signs, toilets. etc.
- Repetitive use of objects or interest in parts of objects: E.g. spinning wheels, lines
- Compulsions/ rituals: Fixed sequence of activities, intrude on family life
- Unusual sensory interests: Sight, touch, sound, taste, smell.
- Hand and finger mannerisms: Flicking, waving, flapping, etc.
- Other complex mannerisms or stereotyped body movements: spinning, bouncing, running in circles, body rocking.

ATTACHMENT 2:
DSM-5 Criteria for Autism Spectrum Disorder

Autism Spectrum Disorder 299.00 (F84.0)

Diagnostic Criteria

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive, see text):

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative paly or in making friends; to absence of interest in peers.

Specify current severity:

Severity is based on social communication impairments and restricted repetitive patterns of behavior (see Table 2).

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat food every day).
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g, strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interest).
4. Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

Specify current severity:

Severity is based on social communication impairments and restricted, repetitive patterns of behavior (see Table 2).

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

Note: Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder.

Specify if:

With or without accompanying intellectual impairment

With or without accompanying language impairment

Associated with a known medical or genetic condition or environmental factor
(**Coding note:** Use additional code to identify the associated medical or genetic condition.)
Associated with another neurodevelopmental, mental, or behavioral disorder
(**Coding note:** Use additional code[s] to identify the associated neurodevelopmental, mental, or behavioral disorder[s].)
With catatonia (refer to the criteria for catatonia associated with another mental disorder, pp. 119-120, for definition) (**Coding note:** Use additional code 293.89 [F06.1] catatonia associated with autism spectrum disorder to indicate the presence of the comorbid catatonia.)

Table 2 - Severity levels for autism spectrum disorder

Severity level	**Social communication**	**Restricted, repetitive behaviors**
Level 3 "Requiring very substantial support"	Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches	Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.
Level 2 "Requiring substantial support"	Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and how has markedly odd nonverbal communication.	Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.
Level 1 "Requiring support"	Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful response to social overtures of others. May appear to have decreased interest in social interactions– e.g., a person who is able to speak in full sentences and engages in communication but whose to-and-fro conversation with others fails, and whose attempts to make friends are odd and typically unsuccessful.	Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence

Benefit Booklet language for ABA

Mental Health and Chemical Dependency Benefits

The Plan provides benefits for the treatment of mental illness and *chemical dependency* by a *hospital*, *doctor* or other provider.

Coverage for *in-network inpatient* and outpatient services is coordinated through your Mental Health Case Manager. The Plan delegates administration of these benefits to the Mental Health Case Manager. To understand more about when you need to contact the Mental Health Case Manager, see "How to Access Mental Health and *Chemical Dependency* Services."

Office Visit Services

The following professional services are covered when provided in an office setting:

- Evaluation and diagnosis
- Medically necessary biofeedback and neuropsychological testing
- Individual and family counseling
- Group therapy.

Outpatient Services

Covered outpatient treatment services when provided in a mental health or *chemical dependency* treatment facility include:

- Each service listed in the section under office visit services
- Partial-day/night hospitalization services (minimum of four hours per day and 20 hours per week)
- Intensive therapy services (less than four hours per day and minimum of nine hours per week).
- Certain *in-network* outpatient services, such as partial hospitalization and intensive therapy, require prior review and *certification* or services will not be covered. Visit the State Health Plan website at www.shpnc.org or call the Mental Health Case Manager for a detailed list of these services. The list of services that require prior review may change from time to time.

Inpatient Services

Covered *inpatient* treatment services also include:

- Each service listed under office visit services
- Semi-private room and board
- Detoxification to treat *chemical dependency*.

Prior review must be requested and *certification* must be obtained in advance for *in-network inpatient* services or services will not be covered, except for *emergencies*.

Applied Behavior Analysis

Coverage is provided for *Applied Behavior Analysis* when all of the following conditions are met:

- The *member* is younger than age 26, and
- Diagnosed with Autism Spectrum Disorder by a licensed physician (MD or DO) or a licensed doctoral level clinical psychologist (PhD or PsyD) utilizing results from a face-to-face evaluation and a clinically recognized, validated tool accepted by the Mental Health Case Manager, and
- Treatment is determined by the Mental Health Case Manager to be medically necessary

Coverage for *Applied Behavior Analysis* is limited to a maximum of $36,000 per benefit year and is only available in-network.

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Applied Behavior Analysis Exclusions

Treatment for the following is not covered:

- *Members* with medical conditions or impairments that would prevent beneficial utilization of services
- *Members* requiring 24 hour medical/nursing monitoring or procedures provided in a hospital setting

ABA treatment will not be certified for the following services:

- Speech therapy
- Occupational therapy
- Vocational rehabilitation
- Supportive respite care
- Recreational therapy
- Orientation and mobility
- Respite Care
- Equine therapy/Hippotherapy
- Dolphin therapy
- Service Animals
- Other educational services

How to Access Mental Health and Chemical Dependency Services

Prior review by the Mental Health Case Manager is not required for any office visit or for out-of-network *inpatient* or outpatient services. Although prior review is not required for *emergency* situations, please notify the Mental Health Case Manager of your *inpatient* stay as soon as reasonably possible.

When you need *inpatient* or outpatient services that require prior review and *certification*, call the Mental Health Case Manager at the number listed in "Who Do I Call?" The Mental Health Case Manager can also help you find an appropriate *in-network provider* and give you information about prior review and *certification* requirements.

Timeframe Requirements for Prior Review and Treatment Certification of Covered Services

Covered Service	Within Two (2) Business Days of Admission	Prior to Admission to the Program	Continuing Treatment Certifications*
Crisis Evaluation & Stabilization	**X**		**X**
Psychiatric Inpatient Hospital	**X**		**X**
Chemical Dependency Inpatient Hospital	**X**		**X**

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Inpatient Medical Detoxification	**X**		**X**
Psychiatric **Residential Treatment Center**		**X**	**X**
Chemical Dependency Residential Treatment Center		**X**	**X**
Psychiatric **Partial Hospitalization Program**		**X**	**X**
Chemical Dependency Partial Hospitalization Program		**X**	**X**
Psychiatric **Intensive Outpatient Program**		**X**	**X**
Chemical Dependency Intensive Outpatient Program		**X**	**X**

**Continuing treatment certifications must be requested by the last date of any previously certified period. Otherwise, certification decisions by the* Mental Health Case Manager *are effective as of the date the request for certification is received by the* Mental Health Case Manager.

Mental Health and Chemical Dependency Services Exclusions

- Care for conditions not classified as psychiatric, emotional, or substance abuse illnesses
- Psychoanalysis
- Counseling with relatives about a patient with mental illness, alcoholism, drug addiction or substance abuse
- *Inpatient* confinements that are primarily intended as a change of environment
- Mental health services received in residential treatment facilities when age 18 or older. Residential treatment facilities are covered for *chemical dependency*.
- Marriage Counseling
- *Inpatient* psychiatric care rendered in a *hospital* not accredited by JCAHO
- *Inpatient chemical dependency* care rendered in a facility which is not currently accredited by a national health care organization approved by the Mental Health Case Manager
- *Inpatient hospital* care for medical detoxification rendered in a facility which is not licensed as a *hospital* and accredited by a national health care organization approved by the Mental Health Case Manager
- Outdoor components of a residential *chemical dependency* treatment program, when such program is licensed as a *chemical dependency* treatment program in the state in which services are provided, are covered only if facility based services are available as a part of the same program
- Primary treatment of a psychiatric disorder in a residential treatment center (RTC) unless the RTC is licensed as a psychiatric RTC
- Primary treatment of a *chemical dependency* or substance abuse disorder in a residential treatment center (RTC) unless the RTC is licensed as a *chemical dependency* or substance abuse RTC
- Services by providers not currently licensed in the state in which services are provided
- Psychotherapy as part of artificial means of conception

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- Psychological assessment and psychotherapy treatment in conjunction with proposed gender transformation
- Psychological testing for those persons with a *chemical dependency* diagnosis until 30 consecutive days of abstinence are obtained.
- Therapeutic boarding schools as a psychiatric residential treatment center (RTC) unless the program is licensed for psychiatric RTC in the state in which services are provided, has registered nurses who are present on-site 24-hours per day, and holds current national accreditation by a national health care accrediting body approved by the Mental Health Case Manager
- Therapeutic boarding schools as a *chemical dependency* or substance abuse residential treatment center (RTC) unless the program is licensed as a *chemical dependency* RTC in the state in which services are provided and has licensed supervision of all residents 24 hours per day, seven days per week
- Wilderness camps, wilderness “step-down” components of a residential program, and stand-alone outdoor treatment programs or outdoor “step-down” components of a residential program are not covered as a psychiatric RTC unless the program is licensed for psychiatric residential treatment in the state in which services are provided, has registered nurses who are present on-site 24-hours per day, and holds current national accreditation by a national health care accrediting body approved by the Mental Health Case Manager
- Wilderness camps and stand-along outdoor treatment programs are not covered as *chemical dependency* or substance abuse RTC programs
- Academic education during residential treatment when charged separately
- Administrative psychiatric services (e.g., expert testimony, report writing, medical records review and maintenance, case management or case coordination, chart review, etc.)
- Consultation with a mental health professional for adjudication of marital, child support, and custody cases
- Evaluations, consultations, testing or therapy for educational, professional training, or for investigation purposes relating to employment, insurance, judicial or administrative proceedings
- Training analysis
- Treatment for personal or professional growth, development, training or professional *certification*
- Aversive Treatment
- Treatment programs based solely on the 12-step Model
- Erhard Seminar Training (EST) or similar motivational services
- Bioenergetic, carbon dioxide, confrontational, hyperbaric or normobaric oxygen, marathon, megavitamin, orthomolecular, primal, rebirthing, or sleep therapies
- Expressive therapies (art, poetry, movement, psychodrama), guided imagery, or stress and relaxation therapy when billed separately
- Telephonic crisis management as a separate charge
- Sedative action, electro stimulation therapy
- Z therapy, also known as “holding therapy”
- Narcotherapy with LSD
- Environmental ecology treatments
- Hemodialysis for schizophrenia
- Rolfing
- Sensitivity training
- Room and Board costs for patients admitted to a partial *hospital* or intensive outpatient program are not covered.

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- Intensive in-home services less than two hours per day
- Private duty nursing
- Therapeutic family, foster or home care
- L-tryptophan and vitamins, except thiamine injections on admission for alcoholism when there is a diagnosed nutritional deficiency
- Travel time necessary for service delivery

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