

Effective: January 1, 2026

Prior Authorization Required If <u>REQUIRED</u> , submit supporting clinical documentation pertinent to service request to the FAX numbers below.	Yes ☒ No ☐
Notification Required IF <u>REQUIRED</u> , concurrent review may apply	Yes ☐ No ☒

Applies to:

Commercial Products

- ☐ Harvard Pilgrim Health Care Commercial products; 800-232-0816
- ☐ Tufts Health Plan Commercial products; 617-972-9409

Public Plans Products

- ☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
- ☒ Tufts Health Together – MassHealth Accountable Care Partnership Plans; 888-415-9055
- ☐ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
- ☐ Tufts Health One Care – A dual-eligible product; 857-304-6304

Senior Products

- ☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-972-9409
- ☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-972-9409
- ☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-972-9409

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

Overview

Applied Behavior Analysis (ABA) is a therapeutic approach that uses principles of learning and behavior to help individuals develop adaptive/functional living skills and reduce behaviors that interfere with daily functioning. ABA focuses on understanding how behavior is influenced by the environment and applying evidence-based techniques to bring about meaningful, measurable changes.

ABA services covered under a health benefit plan are typically delivered in a variety of settings, such as home or community and, as appropriate, ABA provider sites. Members can receive services in emergency departments or on medical surgical floors as appropriate. Services provided in a school setting are distinct and separate from those covered by the health plan and are typically covered by the educational system's special education resources as part of the Individualized Education Program (IEP) pursuant to Public Law 94-142.

Please refer to ABA Performance Specifications for detailed description of service components and staffing requirements.

Admission Criteria: Admission into ABA treatment starts with authorization for an initial assessment to be conducted by the ABA team. The initial treatment plan developed through the initial assessment is then submitted for review and authorization of initial treatment.

Initial Assessment:

All of the following are necessary for medical necessity to be established and receive authorization for the initial assessment.

1. The Member is under 21 years of age.
2. The Member has a confirmed diagnosis of Autism Spectrum Disorder (ASD) and/or Down Syndrome.
 - **ASD:** diagnosis must be made by a licensed physician (e.g., PCP, etc.), Advanced Practice Registered Nurse, Physician Assistant, or Psychologist experienced in the diagnosis and treatment of autism with developmental or child/adolescent expertise.
 - Evidence may be gathered by a multidisciplinary team to assist in the diagnostic process.
 - Documentation used to confer ASD diagnosis must include evidence that aligns with current Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria across ASD core deficits.
 - **Down Syndrome:** The Member has a diagnosis of Down Syndrome from a physician who is licensed and qualified to make such a diagnosis and the diagnosis is confirmed by genetic testing.
3. The diagnostic evaluation contains confirmation of medical screening and assessment to rule out other treatable causes and identify associated comorbidities as indicated.
4. The diagnosis is accompanied by documentation with evidence used to make the diagnosis.

Within 45 calendar days of initial assessment authorization, up to 12 hours of direct and indirect assessment must be completed to inform an initial treatment plan. Requests that fall outside of this standard will only be considered when supported by clear, individualized clinical justification demonstrating medical necessity.

Initial Treatment:

All of the following elements must be included for medical necessity to be established and initial treatment authorized:

1. Required consent for admission obtained from the Member's parent/guardian.
2. An initial treatment plan must be submitted for review
3. Complete medical history to include pre and perinatal, medical, developmental, family, and social elements
 - a. This must include a summary detailing the Member's current natural and formal supports, strengths/weaknesses, and areas of need.
4. Evidence that a record review was completed in collaboration with school, state agencies, physical health practitioners (e.g., PCPs and prescribing clinicians), any outpatient or home/community-based behavioral health services, former treatment teams, or other entities that may impact the Member's treatment.
 - a. Efforts to coordinate care must be ongoing and documented, including attempts of collaboration that were attempted but not successful.
5. Detailed summary of behavioral and/or functional assessment results that include:
 - a. A minimum of two direct observations, with at least one observation in the Member's home and/or naturally occurring community settings.
 - b. Formal assessment data (at least one from each category listed below):
 - i. Validated Skill-based/curriculum tools
 1. Selected assessment must be individualized and selected based on the Member's skill and/or developmental needs to inform goal and treatment plan development
 - ii. Standardized Treatment impact/effectiveness measure
 1. Tools/measures used in this category should measure a Member's improvement over time across domains of functioning or symptoms.
 - iii. Family/caregiver impact (e.g. parent/caregiver surveys, quality of life [QoL] measures, etc.)
 1. Member/caregiver impact measures must be used to inform care planning and service delivery; in the exceptional case that a parent/caregiver is unable to or does not agree to complete caregiver measures, it will not, by itself, delay, deny, reduce, or terminate medically necessary ABA services. Documentation must reflect provider's attempt to administer measure and applicable mitigating efforts.
 - c. A functional behavior assessment or analysis (FBA or FA) and behavior intervention plan (BIP) must be included when treating behaviors for reduction.
6. Evidence that the member demonstrates behavioral or developmental effects of ASD and/or Down Syndrome that either:
 - a. Present a health or safety risk to self or others
 - b. Cause clinically significant impairment of functional participation in the home or community
7. Evidence that ABA treatment will reduce or ameliorate the behavioral and/or developmental effects of the Member's diagnosis to (1) reduce health and/or safety risks towards self-and/or others; and/or (2) restore the Member's functional participation in the home and naturally occurring community settings.
8. Treatment plan contains goals that are individualized, with specific, observable, and measurable objectives that

are developmentally appropriate and focused on functional communication, adaptive skills, and pro-social behavior.

- a. Goal areas may include but are not limited to: cognitive functioning, safety, social skills, age/developmentally appropriate play and leisure, community integration, transitional and coping skills, adaptive/self-help skills, functional communication, attending and social referencing, and reduction of unsafe or maladaptive behaviors.
 - b. Goals must demonstrate how targeted areas will enhance the Member's adaptive and functional living skills.
 - c. Goal descriptions must identify ABA methods, interventions, and reinforcers to be employed, with strategies for generalization and maintenance of skills in natural settings and across parent/caregivers.
9. Complete summary of direct and indirect treatment recommendations across all applicable service components (Licensed Applied Behavioral Analyst [LABA] vs behavioral technician hours, supervision, and parent/caregiver training)
10. In accordance with 130 CMR 450.204, evidence that there is no other medical or behavioral health service or site of service available and suitable for the Member requesting the service, that is more conservative or less costly to the MassHealth agency that is comparable in effect for improving the treatment goals. Some examples of more conservative or less costly services that may address behavioral or developmental effects of ASD and/or Down Syndrome include, but are not limited to:
 - a. Less ABA service hours than is being requested in the treatment plan
 - b. School-based supports through an Individualized Education Program (IEP)
 - c. Early intervention services
 - d. Speech and Language Therapy, Occupational Therapy, or Physical Therapy
 - e. Other behavioral health services, including Children's Behavioral Health Initiative (CBHI)
11. Treatment Setting: ABA services are delivered in the Member's home and/or community settings. In certain cases, center-based services may be authorized when clinically appropriate. Requests for authorization of initial treatment must address the following considerations:
 - a. Treatment must occur in the setting(s) where target behaviors and skill deficits are occurring.
 - b. Treatment setting(s) must accommodate ability for parents/caregivers to meaningfully participate in treatment implementation, generalization, and maintenance
 - c. Treatment setting must be based on the clinical needs of the Member and not determined solely by the convenience of the parent/caregiver or provider.
 - d. Requests for center-based treatment must be supported by data and/or clinical rationale as well as the following components (please refer to ABA Performance Specifications for guidance on use of center-based treatment for group instruction):
 - i. Plan to generalize skills to the Member's naturally occurring environment
 - ii. Individualized titration plan to re-integrate the Member into applicable natural settings
 - iii. Parent/caregiver support plan outlining how the Member and family will be supported outside of center-based sessions
 - e. When center-based services are requested to mitigate safety concerns, review periods may be shorter than six months to monitor progress and safety.
12. Treatment Intensity: There is an absence of conclusive empirical evidence that greater treatment intensity universally produces better outcomes. Therefore, requests for authorization of treatment hours must be individualized to the unique needs of each Member and family.
 - a. The Treatment Intensity Guidance Grid (see below Appendix A) is a clinical decision support tool designed to guide treatment intensity recommendations.
 - b. In addition to intensity levels demonstrated in the Treatment Intensity Guidance Grid, individualized treatment intensity authorization requests must incorporate the following considerations:
 - i. Member's age, developmental level, concurrent services/supports in place, and Member's availability to participate in ABA given other commitments (e.g. concurrent services/supports, family engagement).
 - ii. Member's level of functional engagement at home and appropriate community settings, the severity of symptoms and impairments, the goals of treatment, the expected response, and the Member's previous time spent in ABA treatment.
 - iii. Requested treatment intensity must be supported by data-driven outcome measures and reflect Member and family choice.
 - iv. Intensity levels should not interfere with age or developmentally appropriate participation in family, school, or community activities, nor be determined solely for the convenience of the caregivers or provider.
 - v. Requested treatment intensity should reflect the least intensive level capable of achieving medically necessary goals, with specific criteria to increase or decrease treatment intensity based on objective data.

- vi. An individualized titration plan to re-integrate the Member into less costly, more conservative treatment options while maintaining positive treatment gains.
 - vii. Treatment intensity must reflect time allocated for non-therapeutic activities (e.g., rest breaks, meals, play, and peer interaction). These activities are not reimbursable unless explicitly supported by clinical justification within the ABA assessment, are tied to measurable treatment goals, and are documented accordingly in the Member's medical record.
 - 1. Naps are never reimbursable and must be accommodated as developmentally appropriate.
 - viii. Description of the impact of co-occurring developmental, behavioral, or medical conditions on ABA treatment response.
 - ix. Treatment intensity authorization requests must balance clinical need with Member and family feasibility to ensure access to effective therapeutic levels of intervention and promote treatment adherence.
13. Evidence of planned parent/caregiver involvement as defined in the ABA performance specifications.
 14. Documentation reflects considerations of the Member/family's cultural and linguistic needs.
 15. As applicable, treatment plan is aligned but not duplicative of services that are part of an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) when applicable.

Continuing Stay Criteria:

All of the following criteria are necessary for medical necessity to be established for continuing treatment authorization.

1. The Member's condition continues to meet admission criteria for ABA as outlined above, either due to continuation of presenting problems, or appearance of new problems or symptoms.
2. Treatment plan is individualized and appropriate to the Member's changing presentation with realistic and specific goals and objectives stated.
3. The treatment plan is updated no less than every six months and includes the following:
 - a. Data demonstrating change from baseline across treatment goals
 - b. Data from updated assessment tools as applicable (some assessment tools may require annual updates)
 - c. Updated and/or addition of goals based on the Member's changing presentation
4. Utilization of services reflects appropriate implementation of service components according to ABA performance specifications.
5. The Member's progress is monitored regularly and appropriately documented by:
 - a. Behavioral graphs that visually demonstrate changes from baseline; and
 - b. Daily session notes that summarize:
 - i. Treatment provided;
 - ii. How treatment time was utilized;
 - iii. Member's response to treatment.
6. When progress toward treatment goals is not demonstrated, there is documented evidence that provider has engaged in activities to identify and mitigate barriers to progress. Lack of progress or regression in treatment does not inherently warrant an increase in service hours. Appropriate activities include but are not limited to:
 - a. Evidence of protocol modifications;
 - b. Consideration of alternative or adjunctive levels of care/services;
 - c. Reassessment of intervention effectiveness to support continued medical necessity.
7. There is a reasonable expectation that the Member will continue to benefit from ABA services, as evidenced by data-driven indicators of symptom improvement and measurable progress on treatment effectiveness measures.
8. There is ongoing, documented and individualized planning to generalize and maintain skills across the Member's parent/caregivers and natural settings as applicable and appropriate.
9. There is ongoing documented coordination of care with relevant caregivers and providers involved in Member's care. When coordination is not successful, mitigating factors are documented.
10. There is ongoing evidence of parent/caregiver involvement that aligns with ABA Performance Specifications.
11. Treatment intensity does not exceed the Member and family's functional ability to participate in treatment and demonstrates consideration of other support services in place (e.g. hours in school, speech and language therapy, etc.)
12. Utilization of authorized direct service hours reflects effective levels of treatment adherence.
 - a. Utilization that falls below 75% of approved direct service hours across at least one complete review cycle, may be subject to additional review to determine continuing medical necessity.
 - b. Low utilization alone does not establish lack of medical necessity. Review must consider provider capacity, access barriers, and documented mitigation efforts; must not result in termination where the member continues to meet admission criteria and barriers are being addressed
 - c. If authorization for continued treatment is being requested, documentation must demonstrate the specific

- interventions and strategies implemented to reduce or resolve barriers impacting treatment adherence.
13. Requested direct service hours are not more than what is required to achieve the goals listed in the treatment plan and reflect the Member's and parent/caregiver's ability to participate in treatment.
 - a. Ongoing requests for continued treatment should reflect plans to transition to less intensive treatment models.

Discharge Criteria:

If any of the following criteria are met, the Member must be discharged from ABA treatment:

1. A Member's individual treatment plan and goals have been met.
2. The Member has achieved adequate stabilization of the behavior(s) as defined in the admission criteria, and less-intensive treatment options are appropriate and indicated.
3. The Member no longer meets admission criteria or meets criteria for less- or more-intensive services.
4. The Member and parent/caregiver are not engaged in treatment. Despite multiple, documented attempts to address engagement, the lack of engagement is of such a degree that it implies withdrawn consent or treatment at this level of care becomes ineffective or unsafe.
5. Utilization of direct services falls below 75% of authorized hours AND documentation does not demonstrate medical necessity for continued treatment.
 - a. When discharge is indicated based on an inability to maintain a therapeutically effective level of treatment adherence, documentation must clearly outline the interventions and strategies employed to mitigate or resolve identified barriers to adherence.
6. The Member is placed in a skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting and is not ready for discharge to a family home environment or a community setting with community-based supports.
7. Required consent for treatment is withdrawn.
8. Treatment is making the symptoms persistently worse.
9. The Member is not making progress toward treatment goals, as demonstrated by the absence of documented outcome data, and/or appropriate treatment plan modifications for effective service delivery; there is no reasonable expectation of progress

Exclusion Criteria:

Any of the following criteria are sufficient for exclusion from ABA treatment authorization.

1. Required consent from the Member's guardian is not obtained.
2. The Member is placed in a skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting and is not ready for discharge to a family home environment or a community setting with community-based supports.
3. The Member is receiving ongoing In-Home Behavioral Services (IHBS) or services similar to ABA.
4. The services are replacing school or are being used for educational purposes.
5. The following services are not included within the ABA treatment process and will not be approved:
 - a. Vocational rehabilitation
 - b. Supportive respite care
 - c. Recreational therapy
 - d. Respite care

Codes

The Member must have one of the following ICD-10 diagnoses to be considered for coverage. Please refer to the [Autism Professional Payment Policy](#) for information regarding billing instructions for these services.

Table 1: ICD-10 Codes

Code	Description
F84.0	Autistic disorder
F84.3	Other childhood disintegrative disorder
F84.5	Asperger's syndrome
F84.8	Other pervasive developmental disorders

Code	Description
F84.9	Pervasive developmental disorder, unspecified
Q90.0	Trisomy 21 , nonmosaicism (meiotic nondisjunction)
Q90.1	Trisomy 21, mosaicism (mitotic nondisjunction)
Q90.2	Trisomy 21 , translocation
Q90.9	Down syndrome, unspecified

Table 2: CPT/HCPCS Codes

The following code(s) require prior authorization:

Code	Description
97151	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes
H0031	Mental health assessment, by non-physician - Assessment and treatment planning by a BCBA

Appendix A: Treatment Intensity Guidance Grid

Treatment Intensity Guidance Grid		
The description of different models below are meant to provide general guidance, not fixed requirements for treatment dosing decisions when requesting initial or ongoing ABA services. A Member's treatment needs across functional and behavioral domains may vary, requiring ongoing clinical judgement and individualized reviews when making treatment decisions and determinations. Less intensive treatment models may be appropriate across all levels of functional/behavioral needs when factoring in age, developmental level, available or existing adjunct services, natural supports, and cumulative time in ABA treatment.		
Treatment Model	Typical Treatment Intensity	Example of Functional & Behavioral Needs
Consultative/Targeted	Several hours or days per month of direct / group / family services	Member is mostly able to functionally participate in home and community with current supports and only rarely demonstrates instances of significant impairment
Substantial	Multiple days per week of direct / group / family services	Member requires ongoing direct support across multiple environments to develop, generalize, and/or maintain skills and/or safety
Intensive	20+ hours per week of direct / group / family services	Member requires intensive, frequent support across most/all domains of functioning. Needs are complex and persistent, impacting safety and ability for Member to independently function in natural settings and routines

References:

1. Massachusetts Executive Office of Health and Human Services. MassHealth Medical Necessity Criteria "Applied Behavioral Analysis (ABA)" published August 23, 2016

2. Massachusetts Executive Office of Health and Human Services. MassHealth Medical Necessity Criteria: “Applied Behavioral Analysis (ABA)” updated September 9, 2024.
3. Massachusetts Executive Office of Health and Human Services. MassHealth Medical Necessity Criteria: Applied Behavior Analysis (ABA) [effective January 1, 2026]. Boston, MA: Massachusetts Executive Office of Health and Human Services; 2026.

Approval And Revision History

September 9, 2015: Reviewed by the Medical Policy Approval Committee (MPAC) effective October 1, 2015.

Subsequent endorsement date(s) and changes made:

- October 21, 2020: Reviewed by IMPAC, renewed without changes
- November 4, 2020: Fax number for Unify updated
- November 18, 2020: Reviewed by IMPAC. Addition of code 97156 effective 8/1/2020, revised code description to H2012.
- September 15, 2021: Reviewed by IMPAC, renewed without changes
- April 4, 2022: Template updated
- September 21, 2022: Reviewed by Medical Policy Approval Committee (MPAC), renewed without changes
- April 19, 2023: Reviewed by Medical Policy Approval Committee (MPAC) with the following approved: Removal of codes H0032, H2012 and H2019. Addition of codes 97151, 97153, 97154, 97155, and 97157 which are effective October 1, 2022.
- August 16, 2023: Reviewed by Medical Policy Approval Committee (MPAC), renewed without changes, template updated effective November 1, 2023
- October 24, 2023: Template updated
- November 2023: Rebranded Unify to One Care effective January 1, 2024
- September 19, 2024: Reviewed by MPAC, Renewed with no changes.
- October 17, 2024: Reviewed by MPAC. MNG and criteria updated to reflect revisions to MassHealth Criteria for ABA for September 6, 2024. Name of MNG updated from Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder for MassHealth Members to Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder for Tufts Health Together. Changes effective January 1, 2025.
- November 19, 2025: Reviewed by MPAC for annual review, renewed without changes effective January 1, 2026
- December 2025: Administrative updates effective January 1, 2026.
- December 17, 2025: Reviewed by MPAC. Addition of Down syndrome as eligible diagnosis. Adoption and rebranding of MassHealth criteria, to be effective January 1, 2026.
- February 18, 2026: Reviewed by MPAC. Update to MassHealth Criteria in to reflect revised criteria released January 16, 2026, to be effective January 1, 2026.

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member’s health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.