PHP_3.01	Behavioral Health Treatment		
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Section:	3.0 Mental Health	**Page:**	Page 1 of 24

State Guidelines

Applicable Medi-Cal guidelines as of the publication of this policy (this guideline supersedes the criteria in the Policy Statement section below):

I. Department of Managed Health Care (DMHC) All Plan Letter (APL) Guideline:
- N/A

II. Department of Health Care Services (DHCS) Provider Manual Guideline:
- N/A

III. Department of Health Care Services (DHCS) All Plan Letter (APL) Guideline:
- APL 23-010 – Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21

Below is an excerpt of the guideline language. Please refer to the specific All Plan Letter in the link above for the complete guideline.

Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21
Background:
In accordance with federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements, Medi-Cal provides coverage for all Medically Necessary Behavioral Health Treatment (BHT) services for eligible beneficiaries under 21 years of age. This includes children diagnosed with autism spectrum disorder (ASD) and children for whom a licensed physician, surgeon, or psychologist determines that BHT services for the treatment of ASD are Medically Necessary, regardless of diagnosis.[1, 2]

BHT services include applied behavioral analysis (ABA) and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction. The goal is to promote, to the maximum extent practicable, the functioning of a beneficiary, including those with or without a diagnosis of ASD. Examples of BHT services include behavioral interventions, cognitive behavioral intervention, comprehensive behavioral treatment, language training, modeling, natural teaching strategies, parent/guardian training, peer training, pivotal response training, schedules, scripting, self-management, social skills package, and story-based interventions.

Policy:
For the EPSDT population, state and federal law define a service as "Medically Necessary" if the service is necessary to correct or ameliorate defects and physical and/or mental illnesses and conditions.[3, 4]

Medical necessity decisions are individualized. Therefore, MCPs are prohibited from imposing service limitations on any EPSDT benefit other than medical necessity.

MCPs must comply with mental health parity requirements when providing BHT services. Treatment limitations for BHT services may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits.

I. Criteria for BHT Services for Members Under the Age of 21

When considering a Member's need for BHT services under Medicaid, the MCP must ensure the Member:

1) Has a recommendation from a licensed physician, surgeon, or psychologist that evidence-based BHT services are Medically Necessary and covered under Medicaid;
2) Is medically stable; and
3) Does not have a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities.

II. Covered Services

BHT services must be:

1) Medically Necessary and covered under Medicaid;
2) Provided and supervised in accordance with an MCP-approved behavioral treatment plan that is developed by a BHT service Provider who meets the requirements in California's Medicaid State Plan; and,
3) Provided by a Qualified Autism Service Provider, Qualified Autism Service Professional, or Qualified Autism Service Paraprofessional who meets the requirements contained in California's Medicaid State Plan.[5]

III. Non-Covered Services

Medi-Cal does not cover the following as BHT services under the EPSDT benefit:

1) Services rendered when continued clinical benefit is not expected, unless the services are determined to be Medically Necessary.
2) Provision or coordination of respite, day care, recreational services, educational services, or reimbursement of a parent, legal guardian, or legally responsible person (hereinafter, "Guardian") for costs associated with participation under the behavioral treatment plan.
3) Treatment where the sole purpose is vocationally- or recreationally-based.
4) Custodial care. For purposes of BHT services, custodial care:
   a. Is provided primarily to maintain the Member's or anyone else's safety; and,
   b. Could be provided by persons without professional skills or training.
5) Services, supplies, or procedures performed in a non-conventional setting, including, but not limited to, resorts, spas, and camps.
6) Services rendered by a parent or legal custodian.
7) Services that are not evidence-based behavioral intervention practices.

MCPs are not contractually responsible for educationally necessary BHT services covered by a Local Educational Agency (LEA) and provided pursuant to a Member's Individualized Family Service Plan (IFSP), Individualized Education Program (IEP), or Individualized Health and Support Plan (IHSP). However, if Medically Necessary and covered under Medicaid, the MCP must provide supplementary BHT services, and must provide BHT services to address gaps in service caused when the LEA discontinues the provision of BHT services (e.g., during a public health emergency [PHE]).[6] Lastly, if medically necessary BHT services are otherwise still needed, but the need is not documented in an IEP or IFSP/IHSP, then the MCP may coordinate any needed BHT services in a school-linked setting.

IV. Behavioral Treatment Plan

- BHT services must be provided, observed, and directed under an MCP-approved behavioral treatment plan.

- The behavioral treatment plan must be person-centered and based on individualized, measurable goals and objectives over a specific timeline for the specific Member being treated.
- The behavioral treatment plan must identify the Medically Necessary services covered by Medicaid to be provided in each community setting in which treatment is medically indicated, including on-site at school or during remote school sessions.
- Medically Necessary BHT services provided under the MCP-approved behavioral treatment plan must be provided by qualified Providers in accordance with California's Medicaid State Plan.
- In cases where the MCP-approved behavioral treatment plan includes BHT services provided during school hours, the MCP must ensure effective coordination with the LEA, as necessary.
- The Provider of BHT services must review, revise, and/or modify no less than once every six months the behavioral treatment plan.
- If services are no longer Medically Necessary under the EPSDT medical necessity standard, then the behavioral treatment plan must be modified or discontinued.[3]
- Decreasing the amount and duration of services is prohibited if the therapies are Medically Necessary.
- MCPs must permit the Member's Guardian(s) to be involved in the development, revision, and modification of the behavioral health treatment plan, in order to promote Guardian participation in treatment.

The approved behavioral treatment plan must also meet the following criteria:

1) Include a description of patient information, reason for referral, brief background information (e.g., demographics, living situation, or home/school/work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence-based BHT services.
2) Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors.
3) Identify measurable long-, intermediate-, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation.
4) Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives.
5) Include the Member's current level of need (baseline, expected behaviors the Guardian will demonstrate, including condition under which it must be demonstrated and mastery criteria [the objective goal]), date of introduction, estimated date of mastery, specify plan for generalization and report goal as met, not met, or modified (include explanation).
6) Utilize evidence-based BHT services with demonstrated clinical efficacy tailored to the Member.
7) Clearly identify the service type, number of hours of direct service(s), observation and direction, Guardian training, support, and participation needed to achieve the goals and objectives, the frequency at which the Member's progress is measured and reported, transition plan, crisis plan, and each individual Provider who is responsible for delivering services.
8) Include care coordination that involves the Guardian, school, state disability programs, and other programs and institutions, as applicable.
9) Consider the Member's age, school attendance requirements, and other daily activities when determining the number of hours of Medically Necessary direct service and supervision. However, MCPs must not reduce the number of Medically Necessary BHT hours that a Member is determined to need by the hours the Member spends at school or participating in other activities.

10) Deliver BHT services in a home or community-based setting, including clinics. BHT intervention services provided in schools, in the home, or other community settings, must be clinically indicated, Medically Necessary and delivered in the most appropriate setting for the direct benefit of the Member. BHT service hours delivered across settings, including during school, must be proportionate to the Member's medical need for BHT services in each setting.
11) Include an exit plan/criteria. However, only a determination that services are no longer Medically Necessary under the EPSDT standard can be used to reduce or eliminate services.[3]

V. Coordination of Care

MCPs have primary responsibility for ensuring that EPSDT members receive all Medically Necessary BHT services covered under Medicaid. MCPs must establish data and information sharing agreements as necessary to coordinate the provision of services with other entities that may have overlapping responsibility for the provision of BHT services, including but not limited to Regional Centers (RCs), LEAs, and County Mental Health Plans. When another entity has overlapping responsibility to provide BHT services to the Member, the MCP must:

1) Assess the medical needs of the Member for BHT services across community settings, according to the EPSDT standard;
2) Determine what BHT services (if any) are actively being provided by other entities;
3) Coordinate the provision of all services including Durable Medical Equipment and medication with the other entities to ensure that the MCP and the other entities are not providing duplicative services; and
4) Ensure that all of the Member's medical needs for BHT services are being met in a timely manner, regardless of payer, and based on the individual needs of the Member.

The MCP is the primary Provider of Medically Necessary BHT services for Members eligible for EPSDT. Whenever Members are unable to receive BHT services from school-based Providers or other entities with overlapping responsibility for the provision of BHT services, the MCP is responsible for covering gaps in Medically Necessary services covered under Medicaid for the Member. MCPs are required to provide case management and coordination of care to ensure that Members can access Medically Necessary BHT services. For example, when school is not in session, MCPs must cover Medically Necessary BHT services that were being provided by the LEA when school was in session.

Policy Statement

Any criteria that are not specifically addressed in the above APL, please refer to the criteria below.

NOTES:

- This Medical Policy is based on the work of The Council of Autism Service Providers (CASP), found in their document entitled Applied Behavior Analysis (ABA) Practice Guidelines for the Treatment of Autism Disorder. 3rd edition. All page numbers indicated below refer to the above mentioned document.
- This policy pertains to ABA services only, which may be utilized in the treatment of autism spectrum disorder or pervasive developmental disorder when medically appropriate.
- The "guidelines and recommendations…reflect established research findings and best clinical practices. (p. 1, Applied Behavior Analysis Practice Guidelines for the Treatment of Autism Disorder. 3rd edition, hereafter page references alone will be cited.)
- Refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of BHT/ABA as it applies to the individual member. ***Blue Shield of California***

Promise Health Plan covers BHT/ABA when state mandated or when BHT/ABA is specifically included in a member's benefit plan.

Criteria for Initial Assessment

I. Initial Assessments may be **medically necessary** when **all** of the following criteria are met:
   A. A member diagnosed with autism spectrum disorder or pervasive developmental disorder is new to the requesting provider.
   B. There must be a diagnosis by a licensed, qualified health care provider of autism spectrum disorder based on DSM-5-TR or pervasive developmental disorder using clinical observations or validated assessment tools. ***(Per Medi-Cal guidelines and for Medi-Cal members only: there are no restrictions on diagnoses)***
   C. The provider must request authorization for the initial assessment and include **all** of the following:
      1. Total hours / units of service requested for each CPT code to be billed.
      2. A list of standardized assessments that will be used.
      3. If the total time is more than twenty (20) hours of service, there must be detailed explanation which supports the additional time. (p. 19)
      4. "These assessment activities…(shall) include direct observation and measurement of behavior in conjunction with other activities such as file review, interviews, and the administration of standardized instruments (i.e., a rigorously developed tool that measures a concept in an objective, standardized manner)" (p. 19).

Note: An initial assessment may be performed for the first time for a member, or if this is the first assessment performed by this provider (as in the case where a member changes provider), or if the provider has not seen a previously established member in over 12 months.

Criteria to Initiate Care

II. Initial ABA care may be **medically necessary** when **all** of the following criteria are met:
   A. An initial assessment which must include **all** of the following (p. 2 & p. 19):
      1. There must be a diagnosis by a licensed, qualified health care provider of autism spectrum disorder based on DSM-5-TR or pervasive developmental disorder using clinical observations or validated assessment tools. ***(Per Medi-Cal guidelines and for Medi-Cal members only: there are no restrictions on diagnoses)***
      2. Documentation of the member's baseline skills and problems (functional and skill based assessments) (pgs. 22 – 23)
      3. Standardized assessments ("Well-researched, valid, and reliable standardized assessment instruments that are carefully selected for each patient can provide important information about the strengths and needs of individuals diagnosed with ASD for the purposes of establishing baselines, treatment planning, and evaluating progress." p. 24)
      4. A treatment plan, based on the goals, and assessment data.
      5. Identification of the measures used to report current status and future progress. "These assessment activities…(shall) include direct observation and measurement of behavior in conjunction with other activities such as file review, interviews, and the administration of standardized instruments (i.e., a rigorously developed tool that measures a concept in an objective, standardized manner)" (p. 19).
      6. The treatment plan must be individualized and based on the initial assessment (p. 2 & p. 19).
      7. The treatment plan shall evidence collaboration with family, and caregivers (such as other professionals providing care) (p. 19).
      8. The treatment plan shall include discharge planning (p. 19).
   B. Hours requested for reassessment and report will vary depending on complexity and should be specified by the provider using CPT codes stating hours / units of service requested and be member specific and subject to below guidelines:

1. Up to 20 hours total, over multiple dates of service may be necessary. (p. 19)
2. Total hours should generally be supported by member requirements (e.g., the age, variety of observation settings, the number of interviews and the number of records, which may include prior treatment and or information about co-occurring problems such as thought disorders). (Also refer to pages 20 through 29 for more detailed information related to best practices.) (pgs. 19 – 22, & p. 33)

Note: The working definition, here, for initiation of care is either when a member has never been treated with ABA or it has been more than 12 months since last receiving ABA services.

Criteria for Continued Care

III. Continuation of outpatient behavioral health treatment (BHT)/applied behavior analysis (ABA) may be considered **medically necessary** when **all** of the following criteria are met:
   A. To continue care there must have been either an initial assessment or reassessment within the prior 12 months. (p. 19) ***(Per Medi-Cal guidelines and for Medi-Cal members only: initial assessment or reassessment must have been within the prior 6 months)***
   B. Comparison of baseline and current data. (p. 24 & p. 28) Note: "…a patient who shows no progress on any goals during an authorization period should prompt a careful review of the treatment plan and utilization of authorized services. Similarly, 100% achievement of all goals during a six-month authorization period may indicate that the treatment plan is less ambitious than necessary to deliver critical benefits to the patient." (p. 53)
   C. Updated treatment plan (as needed) based on the current assessment, new goals, goals achieved, lack of progress with goals, and with the collaboration of family, and caregivers (which may include other professionals) and subject to below guidelines. (p. 19, & p. 58)
      1. This should include an analysis of where progress has not been made and,
      2. An explanation of how specific changes can be reasonably expected to produce positive change.
      3. The requested hours of service, by CPT code must be specified by the provider and be supported by information that "reflect(s) the complexity, breadth, and depth of treatment targets, as well as the environment, treatment protocols, and significance of patient needs." p. 33)
      4. Hours for supervision should either be no more than 2 hours of supervision for every ten (10) hours of direct service or have information to support why a higher ratio is medically necessary. (p. 60)
   D. "Each goal should be medically necessary and able to be addressed through behavior analytic practices." (p. 37)
   E. Goals should "…target critical domains, including but not limited to adaptive skills, behavioral concerns, and communication, across all relevant settings…" (p. 37)
   F. The treatment plan shall include transition (fading) / discharge plans and include **all** of the following (pgs. 63 - 64):
      1. "presence or absence of skills"
      2. "the desired outcomes of treatment"
      3. "specify monitoring and evaluation details"
      4. "assessing generalization across environments and people"
      5. "assessing maintenance of treatment gains"
      6. "monitoring the effectiveness of interventions for challenging behavior"
      7. "measuring skill maintenance"
      8. "The transition plan should outline multiple stages of transition, from more support to less support and a more independent level of care."

IV. ABA is considered **not medically necessary** in **any** of the following situations:
   A. "the patient has achieved the desired socially significant outcomes as developed in collaboration between the provider, the patient, and the family, and treatment is not required to maintain functioning or prevent regression, or"

B. "the patient's diagnosis no longer materially impacts functioning, and treatment is not required to maintain functioning or prevent regression, or"
C. "the patient is no longer benefiting from services."

Policy Guidelines

Outpatient behavioral health treatment (BHT)/applied behavior analysis (ABA) is generally *not a covered benefit** for **any** of the following purposes:

- Respite
- Day care
- Educational services
- To reimburse a parent for participation in the treatment

Initial Requests for Services require verification that the member is enrolled with a Local Regional Center.

* See Benefit Application Section

Coding

See the Codes table for details.

Description

Behavioral Health Treatment

Behavioral health treatment (BHT) consists of professional services and treatment programs, including applied behavior analysis (ABA) and evidence-based behavior intervention programs that develop or restore, to the maximum extent possible, the functioning of an individual with autism spectrum disorders.

Applied Behavior Analysis

Applied behavior analysis is a discipline that applies human behavior principles in various settings, i.e., clinics, schools, homes, and communities, to diminish substantial deficits in a recipient's adaptive functioning or significant behavior problems due to autism spectrum disorder. This technique applies interventions to address three core areas of behavioral functioning:

1. Deficits in developmentally appropriate self-care include, but are not limited to:
   - Feeding
   - Grooming
   - Activities of daily living (e.g., dressing, preparing for school)
   - Preoccupation with one or more restricted, stereotyped patterns of behavior that are abnormal in intensity or focus
   - Inflexible adherence to specific, nonfunctional routines or rituals
   - Stereotyped, repetitive motor mannerisms
   - Persistent preoccupation with parts of objects
2. Impairments in social adaptive skills include, but are not limited to:
   - Delay in or lack of spoken language
   - Inability to sustain adequate conversation with others
   - Impairment in non-verbal behaviors in social interaction
   - Failure to develop peer relationships
   - Lack of spontaneous seeking to share emotions in relationships
   - Lack of social or emotional reciprocity
3. Prevention of harm to self or others (safety concerns) include, but are not limited to:

- Aggression directed to self or others (e.g., hitting, biting)
- Engaging in dangerous behaviors (e.g., eating nonfood items, running into the street, elopement)

Autism Spectrum Disorders

The diagnostic category of autism spectrum disorders refers to a group of developmental conditions that involve delayed or impaired communication and social skills, behaviors, and cognitive skills (learning). The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR®) has established a category for autism spectrum disorders which allows for the accountability of variations in symptoms and behaviors.[1]

This medical policy pertains to BHT, including ABA, in the outpatient setting only.

Related Policies

- N/A

Benefit Application

Blue Shield of California Promise Health Plan is contracted with L.A. Care Health Plan for Los Angeles County and the Department of Health Care Services for San Diego County to provide Medi-Cal health benefits to its Medi-Cal recipients. In order to provide the best health care services and practices, Blue Shield of California Promise Health Plan has an extensive network of Medi-Cal primary care providers and specialists. Recognizing the rich diversity of its membership, our providers are given training and educational materials to assist in understanding the health needs of their patients as it could be affected by a member's cultural heritage.

The benefit designs associated with the Blue Shield of California Promise Medi-Cal plans are described in the Member Handbook (also called Evidence of Coverage).

Regulatory Status

These guidelines adhere to the standards established by the Council of Autism Service Providers (CASP) to ensure compliance with California Senate Bill 855 concerning health coverage for mental health or substance use disorders.

Health Equity Statement

Blue Shield of California Promise Health Plan's mission is to transform its health care delivery system into one that is worthy of families and friends. Blue Shield of California Promise Health Plan seeks to advance health equity in support of achieving Blue Shield of California Promise Health Plan's mission.

Blue Shield of California Promise Health Plan ensures all Covered Services are available and accessible to all members regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, and that all Covered Services are provided in a culturally and linguistically appropriate manner.

Rationale

Autism spectrum disorder (ASD)

Autism spectrum disorder is a new category presented in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR®). Symptoms can range from mild to severe and commonly involve impairment or disability with communication skills, motor skills, and social skills. According to data from the Centers for Disease Control and Prevention (CDC) in the 2020 surveillance year, the estimated prevalence of ASD is 1 in 36 children in the United States and is nearly 4 times more common in boys than among girls.[7]

Autism Spectrum Disorder is characterized by the following[8]:

- Difficulty with communication and interaction with other people
- Restricted interests and repetitive behavior
- Symptoms that affect their ability to function in school, work, and other areas of life

Currently there is no cure for autism spectrum disorders or any one single treatment for the disorder. ASD's may be managed using various combinations of therapies including behavioral, cognitive, pharmacological, and education learning. The goal of treatment is to minimize the severity of symptoms, maximize learning, facilitate social integration, and improve quality of life for individuals with the disorder as well as their families and/or caregivers.[9] Better outcomes have been associated with earlier diagnosis and implementation of treatment. Children with normal to higher intelligence quotients (IQs) and good language skills without comorbidities (e.g., seizure, psychiatric disorders) also appear to have more favorable outcomes. Interventional treatment plans are directed at developing the child's functional strengths and addressing the learning disability weakness.

Health and Safety Code

This medical policy is based on the California Health and Safety Code Section 1374.73 which requires insurers provide coverage of BHT for individuals with autism spectrum disorders. This law became effective July 1, 2012.

According to Health and Safety Code Section 1374.73, "Behavioral health treatment means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism…"[10]

As taken directly from the California Health and Safety Code Section 1374.73, BHT must meet all of the following criteria[10]:

- The treatment is prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of, or is developed by a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the Business and Professions Code.
- The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:
  - A qualified autism service provider.
  - A qualified autism service professional supervised by the qualified autism service provider.
  - A qualified autism service paraprofessional supervised by a qualified autism service provider or qualified autism service professional.
- The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall

be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:
  - Describes the patient's behavioral health impairments or developmental challenges that are to be treated.
  - Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.
  - Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.
  - Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.
- The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the health care service plan upon request.

A qualified autism service provider is defined as either of the following:
- A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified.
- A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

A qualified autism service professional is defined as an individual who meets all of the following criteria:
A. Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider.
B. Is supervised by a qualified autism service provider.
C. Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.
D. Is either of the following:
   (i) Is a behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program.
   (ii) A psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology.
E. (i) Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

(ii) If an individual meets the requirement described in clause (ii) of subparagraph (D), the individual shall also meet the criteria set forth in the regulations adopted pursuant to Section 4686.4 of the Welfare and Institutions Code for a Behavioral Health Professional.

F. Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

A qualified autism service paraprofessional is defined as an unlicensed and uncertified individual who meets all of the following criteria:

- Is supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice.
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.
- Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.
- Has adequate education, training, and experience, as certified by a qualified autism service provider or an entity or group that employs qualified autism service providers.
- Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

Additionally, a health insurer may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing.

NOTE: A board certified behavioral analyst (BCBA) could prescribe ABA treatment for autism spectrum disorder or pervasive developmental disorder.

Applied Behavior Analysis

Applied behavior analysis therapy is the design, implementation, and evaluation of systematic instructional and environmental modifications to promote positive social behaviors and reduce or ameliorate behaviors which interfere with learning and social interaction.

The first demonstrations of the effectiveness of this treatment model occurred in the 1960s with the employment of highly structured operant conditioning learning programs to improve the condition of recipients with autism and mental retardation. Many techniques, strategies, and approaches have been developed using ABA as a foundation. ABA treatments derive from the experimental analysis of behavior – a field dedicated to understanding how environmental events affect behavior.

ABA systematically applies interventions based on learning theory to improve social interaction, verbal and nonverbal communication, and maladaptive or challenging behavior while demonstrating that the interventions employed are responsible for the improvement. Deficits in functioning may be due to environmental factors, physical conditions, mental health disorders, and psychological factors. The severity and frequency of maladaptive behavior, e.g., aggression, violence, destructiveness, and self-injury, may result in risk to the physical safety of the individual or others. ABA involves the analysis, design, implementation, and evaluation of behavior modification plans to produce significant improvement in behavior. ABA programs include multiple techniques (e.g., discrete trial training and naturalistic teaching) and integrate different strategies based on the recipient's needs and target goals. The ABA literature universally cites the need for caregiver training and caregiver assumption of treatment interventions. ABA methodologies incorporate data collection to monitor the recipient's progress and evaluate the effectiveness of the intervention.

General ABA behavior goals in autism include: (1) increasing selected behaviors, (2) teaching new skills, (3) maintaining selected behaviors, (4) generalizing or transferring selected behaviors, (5) restricting or narrowing conditions under which interfering behaviors occur, (6) reducing interfering

behaviors, and (7) parental skill development and the application of those skills in natural settings. Socially significant behaviors frequently targeted include addressing underlying issues that impair academic functioning, social skills, communication and adaptive living skills, e.g., eating and food preparation, toileting, dressing, personal self-care, domestic skills, time and punctuality, money and value, home and community orientation and work skills. Please note that gross and fine motor skills should come under the responsibility of Occupational Therapy, or other therapeutic interventions that do not fall within the scope of ABA.

Functional Behavior Assessment

Functional Behavior Assessment (FBA) or Functional Analysis is a rigorous method of gathering information about problem behaviors. The underlying theory of FBA is that most problem behaviors serve some type of an adaptive function reinforced by consequences. FBA is used in both designing a behavior program for maximum effectiveness and serves as the foundation of the individualized treatment plan.

Focused vs Comprehensive ABA

"Scope of treatment should be aligned with the breadth and depth of behaviors targeted to address the needs of each patient. Scope of treatment is operationalized in the overall goal of treatment as well as in specific objectives and behavioral targets. Appropriate scope is determined by multiple data sources, including but not limited to direct and indirect assessments and the patient's response to treatment. Scope of treatment can be conceptualized as existing on a continuum, with "comprehensive" representing one end and "focused" representing the other.

When a treatment plan is in-depth and broad in scope (i.e., comprehensive), it typically encompasses multiple simultaneous goals within and across multiple domains, such as language, behavior, activities of daily living, social skills, and cognition. The desired therapeutic effects can be achieved only through multiple associated behavior changes. In general, comprehensive programs also require sufficient intensity of services (i.e., sufficient dosage) to ensure that progress is made toward all treatment goals. For example, effective functioning within social communities necessitates achieving objectives for multiple, complex behaviors across many domains (e.g., language, perspective-taking, leisure skills). In contrast, a treatment plan that is narrow in scope (i.e., focused) generally targets one or two domains or areas of concern. For example, treatment might focus exclusively on tolerating and cooperating with medical procedures (e.g., taking oral medication, having vitals taken, receiving injections to manage diabetes). Even though the scope is narrower, this type of programming can be complex and time-intensive, as it may require multiple prerequisite behaviors and numerous phases before the therapeutic goal is met.

Focused ABA

Focused ABA refers to treatment, provided directly to the patient, to improve or maintain behaviors in a limited number of domains or skill areas. Access to focused intervention should not be restricted by age, cognitive level, diagnosis, or co-occurring conditions.

Focused ABA treatment is appropriate for patients who:

a) need to acquire a limited number of skills fundamental to health, safety, inclusion, and independence. Such behaviors may include but are not limited to safety skills, following instructions, social skills, self-care, communication, feeding, toileting, cooperating with medical and dental routines, and participating in independent leisure activities.
   or
b) demonstrate challenging high-risk behaviors that must be prioritized due to health and safety concerns. In many cases, addressing these behaviors in a timely fashion is critical as they can also interfere with treating other medical needs. Examples of challenging behaviors that may be the focus of intervention include but are not limited to self-injury, property destruction, aggression toward others, inappropriate sexual behavior, threats, pica,

elopement, stereotypic motor or vocal behavior, challenges with routines related to safety or adaptive functioning, disruptive behavior, and dysfunctional social behavior.

Focused ABA treatment may be delivered solely to increase adaptive behaviors (e.g., oral care, independent toileting). However, when the focus of treatment is the reduction of challenging behavior (e.g., pica, property destruction), establishing alternative adaptive behavior should be included in the treatment plan. The absence of adaptive behavior such as functional communication or leisure skills often sets the stage for the emergence of serious behavior disorders and leaves patients with limited opportunities to access meaningful reinforcers.

When the main purpose of treatment is the reduction of challenging behavior, the behavior analyst identifies situations in which the behavior occurs to determine its purpose or function for that patient. Understanding the function may necessitate a specific type of assessment, known as a functional analysis, that involves systematically varying environmental events to measure the effects on the behavior of interest. When the function of the challenging behavior has been identified, the behavior analyst designs a treatment plan that alters the environment to reduce the motivation for the challenging behavior and/or establish an alternative adaptive behavior.

Some patients display significant challenging behaviors that require treatment in specialized settings (e.g., intensive outpatient, day treatment, residential, or inpatient programs). Such treatment typically requires high staff-to-patient ratios (e.g., 2–3 staff members for each patient) and close on-site direction by the behavior analyst. These programs often utilize specialized equipment and treatment environments, such as observation rooms and room adaptations, which aid in maintaining the safety of both patients and staff.

When the primary purpose of focused treatment is to increase socially appropriate behavior, services are often delivered in dyads or small groups. In this setting, patients with similar or varying disorders, and/or typically developing peers, are often included. The treatment team supports the practice of behavioral targets in the treatment session but also programs for the generalization of skills outside those sessions. Some patients may require 1:1 treatment sessions either prior to or concurrently with group sessions for the group format to be an appropriate treatment modality.

Comprehensive ABA

Comprehensive ABA refers to treatment provided directly to the patient to improve or maintain behaviors in many skill areas across multiple domains (e.g., cognitive, communicative, social, behavioral, adaptive). Treatment often emphasizes establishing new skills but may also focus on reducing challenging behaviors, such as elopement, and stereotypy, among others. Access to comprehensive ABA should not be restricted by age, cognitive level, diagnosis, or co-occurring conditions.

Treatment targets are generally drawn from the following domains:

- adaptive and self-care
- attending and social referencing
- cognitive functioning
- community participation
- coping and tolerance
- emotional development
- family relationships
- language and communication
- play and leisure
- pre-academic skills
- reduction of challenging behavior
- safety skills

- self-advocacy, independence, and autonomy
- self-management
- social relationships
- vocational skills

One example of comprehensive treatment is intensive ABA treatment for young children with ASD. In this example, the primary goal of treatment is to close or narrow the gap in development compared with peers.

Intervention must be implemented as early as possible to improve the developmental trajectory of children diagnosed with autism. Effective early intervention focuses on establishing foundational skills, such as environmental awareness, imitation, functional communication, self-management, daily living skills, and the building blocks for social interaction. These foundational skills reduce the pervasive impact of ASD and minimize the likelihood of additional disability in the form of intellectual impairment. In addition to building skills, early development is the optimal period to reduce and mitigate challenging behaviors.

The proportion of treatment time spent on any given domain is subject to the individual needs of the patient and family. For example, when establishing foundational "learning to learn" skills (e.g., imitation, observational learning, discrimination), treatment time devoted to other skills may be reduced to allow a greater focus on the skills that will transform learning and progress in subsequent areas (i.e., pivotal skills). In addition, slow rates of progress may signal the need to increase the amount of treatment to establish critical skills.

As noted above, comprehensive treatment should not be limited by age, as this type of program can be appropriate for adolescent and adult patient populations. For example, persons who engage in harmful and risky behaviors and/or have substantial deficits in skills that jeopardize their health, safety, and independence may require such programs.

Comprehensive treatment may be 1:1 initially, with gradual transitions to small-group formats as appropriate. Treatment may be provided in structured sessions or using naturalistic methods depending on the individual needs of the patient. As the patient progresses and meets criteria to receive treatment in other places, services may be provided in multiple settings.

Multiple considerations are relevant to determining appropriate treatment intensity. Patients should be able to receive treatment at the intensity that is most effective to achieve treatment goals. When there is uncertainty regarding the appropriate level of service intensity, the practitioner should err on the side of caution by providing a higher level of service intensity. Evidence of failure at a lower level of service intensity should not be required to access a higher intensity of care.

Decisions to adjust treatment intensity should be individualized and based on the patient's response to treatment (i.e., data supporting the need to increase or decrease). Decisions should not be based on the length of time receiving treatment and/or the age of the individual receiving care. Moving to a lower level of intensity is appropriate only when it is deemed safe to do so and when the lower level is equally effective as treatment at the higher level or service intensity. Clinicians who have directly observed and treated the patient are best positioned to recommend the appropriate number of treatment hours per week.

The recommended intensity of treatment should be based on what is medically necessary for the patient independent of the patient's schedule of activities outside of treatment or previous utilization of services. Practical variables may be considered, but when there is conflict that may impact treatment outcomes, medical necessary considerations should be paramount.

Treatment intensity is specified in the treatment plan and defined as the number of direct ABA treatment hours per week, not including case supervision by the behavior analyst, caregiver training, and other services. Additionally, hours spent in educational settings and receiving IEP services should not be included in the calculation of treatment hours. The number of service hours is a proxy for the total number of therapeutic interactions, such as learning opportunities, taking into account their complexity. Treatment intensity should reflect the complexity, breadth, and depth of treatment targets, as well as the environment, treatment protocols, and significance of patient needs. The best available evidence demonstrates that intensity of treatment dosage is the best predictor of achieving meaningful treatment outcomes.

Given that comprehensive ABA treatment addresses numerous target skills across multiple domains, many hours of direct services each week should be provided for an extended duration to ensure that the patient has sufficient opportunities to learn and practice. Multiple studies have shown that 30-40 hours of direct treatment per week produce better outcomes than treatment at lower dosages in comprehensive programs for young children with autism. Similar intensities would typically be medically necessary in comprehensive programs for adolescents and adults to meet treatment objectives.

Focused ABA typically involves fewer domains than comprehensive treatment models, with services often comprising 10–25 hours of direct treatment per week. However, there are exceptions. For example, treating challenging behaviors or severe feeding concerns that threaten the patient's health and safety or significantly interfere with their progress may be so complex that it requires substantial intensity to achieve an acceptable outcome (i.e., greater than 10-25 hours of direct treatment per week).

Scope of treatment and treatment intensity are generally positively correlated, as shown in the diagram below. This diagram depicts scope as one continuum, with comprehensive and focused as the endpoints and a second, intersecting continuum of intensity with low and high as the endpoints. Examples are provided for each combination of scope and intensity. For example, an individual may start out in a program like those depicted in the upper right quadrant (e.g., comprehensive/high intensity) and later transition into a program represented in the upper left quadrant (e.g., comprehensive/low intensity) to focus on maintaining previously acquired skills. That patient might even be completely discharged from services but later re-enter services for a focused program consistent with either of the lower quadrants when a new concern emerges (e.g., difficulty with dating). For other individuals, a comprehensive treatment plan may remain the most appropriate treatment plan. These examples should not be interpreted as an exhaustive list of potential ABA services.

In general, low-intensity, broad-scope treatment plans are appropriate only to maintain well-established behavior changes. Treatment plans that address a limited number of behavioral targets across limited domains may allow for adequate progress at relatively lower intensities. However, as the number and complexity of targets increase along with the number of domains addressed, a higher intensity of treatment becomes necessary. Without this correspondence, the constraints on the number of learning opportunities will limit the progress that can be achieved.

Regardless of whether the treatment is focused or comprehensive, the specific number of hours of services should be individually determined based on data collected during evaluations, assessments, and clinical impressions. Providers assess treatment needs and required dosage based on a multidimensional assessment that considers a wide variety of information about the patient" (pgs. 29 – 34 CASP 3rd Edition).

Desired Outcome

The desired outcomes for discharge should be specified at the initiation of services and refined throughout the treatment process. Transition and discharge planning from a treatment program

should include a written plan that specifies details of monitoring and follow-up as is appropriate for the individual and the family. Parents, community caregivers and other involved professionals should be consulted ongoing and prior to the planned reduction of service hours. Additional services, including behavioral therapies and other supports, should be considered for the child and family as care is faded to lower frequency.

Summary of Evidence

Blue Shield of California Promise Health Plan will provide coverage for medically necessary outpatient BHT/ABA services for individuals when the BHT/ABA services are ordered and deemed medically necessary based on the specific applicability and criteria outlined by Health and Safety code 1374.73 and in the Blue Shield of California Promise Health Plan Medical Policy.

Appendix 1

Behavioral health treatment (BHT) is also referred to as intensive behavioral intervention (IBI), early intensive behavioral intervention (EIBI), or applied behavior analysis (ABA) including Lovaas-based approaches. Applied behavior analysis focuses on remediating the child's delay in communication, social and emotional skills and places great focus on integrating the child with peers in typical settings.

ABA systematically applies interventions based on learning theory to improve social interaction, verbal and nonverbal communication, and maladaptive or challenging behavior while demonstrating that the interventions employed are responsible for the improvement. Deficits in functioning may be due to environmental factors, physical conditions, mental health disorders, and psychological factors. The severity and frequency of maladaptive behavior (e.g., aggression, violence, destructiveness, and self-injury) may result in risk to the physical safety of the individual or others. ABA involves the analysis, design, implementation, and evaluation of behavior modification plans to produce significant improvement in behavior. ABA programs include multiple techniques (e.g., discrete trial training and naturalistic teaching) and integrate different strategies based on the recipient's needs and target goals. ABA methodologies incorporate data collection to monitor the recipient's progress and evaluate the effectiveness of the intervention and evaluate behavior with validated tools and objective developmental norms. An ABA program is directed to promoting the greatest level of independence possible for the recipient and provides training and support for the caregivers.

Essential Elements of Effective ABA Treatment

1. An objective assessment and analysis of the client's condition by observing how the environment affects the client's behavior, as evidenced through appropriate data collection and the use of validated assessment tools and developmental norms.
2. An understanding of the context of the behavior and the behavior's value to the individual, the family, and the community and a plan to address the most socially significant deficits in skill or problem behaviors that will allow the independent functioning for the recipient across these environments.
3. A thorough review of the recipient's medical, educational, and psychological and behavioral history and ongoing coordination of care with other providers involved in the recipient's treatment (e.g., physical therapists, social workers, occupational therapists, pediatricians, speech therapists).
4. The use of ongoing, objective assessments and data analysis to inform clinical decision making.
5. A focus on the recipient's quality of life, with care provided only for as long as necessary to achieve goals, or maximize clinical benefit, and promote independence for the recipient.
6. The facilitation of opportunities for the recipient to interact with typically-developing peers.

7. The inclusion of the recipients'' caregivers in a formalized program of training that allows them to develop skills and apply these in naturalized settings to further the recipient's treatment goals.
8. A strong program of support for the caregivers that addresses the stresses and strains of caregiving including community connection to supportive resources.

Initial Evaluation

After an initial diagnosis has been obtained from an appropriate provider (e.g., pediatrician, pediatric neurologist, developmental pediatrician, psychologist), a functional behavioral assessment (FBA) should be completed that includes observation across all relevant settings (e.g., home, school and community). The intent of the FBA is to develop a thorough plan of interventions that will target reductions in problematic behaviors, in addition to the promotion of more adaptive skills and behaviors. The FBA captures baseline data and will design a plan of ongoing data collection that will inform the duration and intensity of services. The FBA will include a plan for the training of the recipient's caregivers, complete with goals for the caregivers and a plan to train and support the caregivers. The FBA should include:

1. Validated developmental and adaptive skills assessment (e.g. ABAS, Bayley or Vineland,) to establish baseline functioning.
2. Review of the recipient's medical, psychiatric, educational records.
3. An evaluation of the purpose of maladaptive behaviors using a validated assessment tool (e.g., QABF, FAST, FACT).
4. Caregiver interview.
5. Evidence of coordination of services with the recipient's other treatment providers.
6. Consideration for the recipient's medications and medical comorbidities.
7. A detailed description of behavior reduction goals with clear definition, antecedent, baseline, and mastery criteria for needed skills development.
8. A detailed description of replacement behavior and skill acquisition goal selection based on reported behaviors and developmental evaluation scores.
9. Caregiver training goals and a plan to provide necessary support and training to caregivers as well as a plan to evaluate their acquisition of these skills.
10. A detailed proposal for the intensity and duration of services, as well as the locations where those services will be provided.
11. Full documentation of any IEP services the recipient is receiving and a description of how the proposed care will coordinate with the established IEP.
12. An indication of other services that will be necessary such as physical therapy or family therapy, and documentation that such referrals have been provided.
13. A clear plan with objective milestones for the systematic reduction of care and the criteria for discharge from services.

Ongoing Services

1. Validated developmental and adaptive skills assessment (e.g., ABAS, Bayley, or Vineland) should be administered every six (6) to twelve (12) months to evaluate progress from baseline functioning.
2. Care should be applied as prescribed in the treatment plan, and behavior tracking should be completed such that the occurrence and frequency of maladaptive behaviors as well as replacement behaviors are captured graphically.
3. Antecedents to behavior should be noted as well as response to interventions.
4. The setting of ongoing services should be documented as well as participants present during the intervention.
5. Interventions should promote the recipient's independence and should be focused on those behaviors that interfere with the recipient's self-care abilities, the recipient's safety and those behaviors that interfere with the recipient's communication and interaction with others.

6. Caregivers are participating in training and interventions such that the treating professional can fade out of the intervention and the caregiver can effectively achieve the goal of the intervention over time.
7. Caregivers should have specific behavior goals that generalize treatment benefits across multiple settings and allow treatment progress to be maintained over time.
8. The recipient should be presented with opportunities to demonstrate skills acquisition with developmentally-typical peers.
9. Adjustments to treatment interventions will be made in consultation with the BACB supervisor, and the reason for these adjustments will be well documented in the clinical record, including the goals and the behavior tracking of these goals.
10. A detailed tracking of the intensity of services as well as the locations where those services are provided shall be maintained in the treatment record.
11. Coordination with other services such as physical therapy or family therapy should be ongoing.
12. Measurement of progression on milestones should be captured on an ongoing basis and progress to discharge goals should be noted.

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Documentation for Clinical Review

Please provide the following documentation:

- History and physical and/or consultation notes including:
  - Documentation of the type and degree of behaviors needing treatment
  - Functional assessment
  - Clinical findings (i.e., pertinent symptoms and duration)
  - Comorbidities
  - Activity and functional limitations
  - Family history, if applicable
  - Reason for procedure/test/device, when applicable
  - Pertinent past procedural and surgical history
  - Past and present diagnostic testing and results
  - Prior treatment plans, treatments, duration, and response
  - Proposed/current treatment plan including but not limited to the anticipated response to treatment, goals and other types of treatment that have been tried (with results) or considered but excluded
  - For continuation, documented progress/improvement (if applicable) but not having yet met goals; why gains cannot be maintained with a lower level of care; and that treatment has not worsened issues
- Consultation and medical clearance report(s), when applicable
- Copy of the most current individualized education program (IEP)/intervention support program (ISP) (if applicable)
- Documentation of enrollment with local Regional Center
- Discharge summary from earlier treatment (if applicable/available)
- Other pertinent multidisciplinary notes/reports: (i.e., psychological or psychiatric evaluation, physical therapy, speech therapy, occupational therapy, multidisciplinary pain management), when applicable

Post Service (in addition to the above, please include the following):

- Results/reports of tests performed

- Procedure report(s)
- Documentation of treatment hours provided

Coding

The list of codes in this Medical Policy is intended as a general reference and may not cover all codes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy.

Type	Code	Description
CPT®	0362T	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.
	0373T	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.
	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
	97152	Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes
	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

Type	Code	Description
	97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes
HCPCS	G9012	Other specified case management service not elsewhere classified
	H0031	Mental health assessment, by nonphysician
	H0032	Mental health service plan development by nonphysician
	H0046	Mental health services, not otherwise specified
	H2014	Skills training and development, per 15 minutes
	H2019	Therapeutic behavioral services, per 15 minutes
	S5108	Home care training to home care client, per 15 minutes
	S5110	Home care training, family; per 15 minutes
	S5111	Home care training, family; per session

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
11/01/2025	New policy.

Definitions of Decision Determinations

Healthcare Services: For the purpose of this Medical Policy, Healthcare Services means procedures, treatments, supplies, devices, and equipment.

Medically Necessary or **Medical Necessity** means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

For Members less than 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member's current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the Child.

Criteria Determining Experimental/Investigational Status
In making a determination that any procedure, treatment, therapy, drug, biological product, facility, equipment, device, or supply is "experimental or investigational" by the Plan, the Plan shall refer to evidence from the national medical community, which may include one or more of the following sources:

1. Evidence from national medical organizations, such as the National Centers of Health Service Research.
2. Peer-reviewed medical and scientific literature.
3. Publications from organizations, such as the American Medical Association (AMA).
4. Professionals, specialists, and experts.

5. Written protocols and consent forms used by the proposed treating facility or other facility administering substantially the same drug, device, or medical treatment.
6. An expert physician panel selected by one of two organizations, the Managed Care Ombudsman Program of the Medical Care Management Corporation or the Department of Managed Health Care.

Feedback

Blue Shield of California Promise Health Plan is interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration. Our medical policies are available to view or download at www.blueshieldca.com/en/bsp/providers.

For medical policy feedback, please send comments to: MedPolicy@blueshieldca.com

Questions regarding the applicability of this policy should be directed to the Blue Shield of California Promise Health Plan Prior Authorization Department at (800) 468-9935, or the Complex Case Management Department at (855) 699-5557 (TTY 711) for San Diego County and (800) 605-2556 (TTY 711) for Los Angeles County or visit the provider portal at www.blueshieldca.com/en/bsp/providers.

Disclaimer: Blue Shield of California Promise Health Plan may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as member health services contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member health services contracts may differ in their benefits. Blue Shield of California Promise Health Plan reserves the right to review and update policies as appropriate.