KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Applied Behavior Analysis (ABA) Medical Necessity Review Process	**Policy #**	30.93-P
Policy Owner	Utilization Management	**Original Effective Date**	10/01/2025
Revision Effective Date		**Approval Date**	11/20/2025
Line of Business	☒ Medi-Cal ☐ Medicare ☐ Corporate		

I. PURPOSE

A. The purpose of this policy is to:

1. Establish standardized, evidence-based Behavioral Health Treatment (BHT) services in alignment with nationally recognized Applied Behavior Analysis (ABA) guidelines, industry best practice standards, and regulatory requirements.

2. Ensure that all Functional Behavioral Assessments (FBAs), behavioral treatment plans, and progress reports:

   a. Comply with California Department of Health Care Services (DHCS) requirements, including All Plan Letter (APL) 23-010.
   b. Fulfill Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) obligations for members under age 21.
      i. Medical necessity decisions are individualized. Therefore, Managed Care Plans (MCPs) are prohibited from imposing service limitations on any EPSDT benefit other than medical necessity. The determination of whether a service is Medically Necessary for an individual Member must be made on a case-by-case basis, considering the particular needs of the Member.
      ii. Please refer to Kern Health Systems (KHS) P&P UM-21.06 P. Titled “Behavioral Health Treatment Responsibilities for Members Under the Age 21”.

   c. Document medical necessity and clinical appropriateness of services.
   d. Maintain compliance with payer and regulatory requirements.

II. POLICY

A. KHS has primary responsibility for ensuring members needs for medically necessary BHT include children diagnosed with autism spectrum disorder (ASD) and children for whom a licensed physician, surgeon and clinical psychologist determines that BHT services for treatment of ASD are medically necessary, regardless of diagnosis. KHS will cover all services that maintain the member's health status, prevent a member's condition from worsening, or that prevent the development of additional health problems.

B. Guiding Principles

1. ABA service hours must be individualized, clinically justified, and supported by assessment data.

2. Determinations will align with nationally recognized ABA guidelines, industry standards, and payer-specific medical necessity criteria.

3. Recommendations must consider:

a. FBA results and standardized skill assessments,
b. Client-specific skill deficits, maladaptive behavior severity, and treatment goals,
c. Caregiver participation and training needs,
d. Treatment setting and generalization requirements,
e. Comprehensive Diagnostic Evaluation, if completed and available,
f. Individualized Education Plan (IEP) and/or 504 plan, if available and relevant.

C. Eligibility for BHT Services

1. The Member must be:

a. Under 21 years of age,
b. Medically stable,
c. Not require 24-hour medical/nursing monitoring in a hospital or Intermediate Care Facility (ICF).
d. Have ABA treatment recommended by a physician, psychologist, or surgeon,
e. Present with developmentally inappropriate behaviors that significantly impair functioning across environments,
f. Not have behaviors solely explained by an untreated medical condition, sensory impairment, or mental health disorder better treated by another modality.

D. Medical Necessity Criteria

1. Medical Necessity Criteria in general are “practice guidelines” “treatment guidelines” and “generally accepted standards of care used for the purpose of:

    a. Evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms in accordance with the accepted standards of practice that are clinically appropriate and not primarily for the convenience or fiscal benefit of the patient, health care provider, or other clinicians or health care providers and,
    b. Are efficient and cost effective.

2. The medical-necessity decision making process utilized by KHS is to determine the type and intensity of services a member requiring ABA services will need.

3. KHS requires that ABA service requests will undergo medical necessity review based on:

    a. The requirement of a complete assessment using validated tools and standardized developmental norms,
    b. Focused interventions,
    c. Care giver participation,
    d. Repeated measurements with standardized measures to assess progress based on measurable gains in functioning and standardized measures to assess progress.

4. Medical Necessity criteria sets utilized by KHS include:

    a. Medi-Cal Provider Manual
    b. Current edition of Milliman Care Guidelines (MCG) Behavioral Health Guidelines,
    c. DHCS APL 23-010 Behavioral Health Treatment Responsibilities for Members under the Age of 21,

E. Non-Covered Services

1. ABA services are not covered when:

    a. No continued clinical benefit is expected,
    b. Provided as respite care,
    c. Delivered in daycare, camps, resorts, spas, or non-conventional settings,
    d. Provided for custodial care (e.g., safety monitoring without skill acquisition),
    e. Solely vocationally or recreationally based,
    f. Educational goals that are solely for academic advancement and not tied to functional skill

development or medically necessary behavioral outcomes.

g. Not supported by industry standards or national guidelines.

III. DEFINITIONS

TERMS	DEFINITIONS
Board Certified Behavior Analyst (BCBA)	A professional certified in applied behavior analysis (ABA) who designs, oversees, and evaluates behavior intervention plans. BCBAs hold a graduate-level certification and are responsible for supervising ABA therapy and ensuring treatment aligns with best practices.
Qualified Autism Service Provider (QASP)	An organization or entity approved to provide autism-related services under Medi-Cal, including ABA therapy. A QASP employs professionals and paraprofessionals who meet state and program-specific qualifications.
QASP Professional	An individual employed by a QASP who delivers ABA services directly to members and meets the required educational, training, and competency standards (e.g., Registered Behavior Technician or similar).
QASP Paraprofessional	An individual employed by a QASP who assists in the delivery of ABA services under the supervision of a QASP Professional or BCBA, typically providing direct care and support but without full professional credentials.
Functional Behavior Assessment (FBA)	A structured process, conducted by a qualified professional such as a BCBA, to identify the reasons behind challenging behaviors in individuals with autism or other developmental disorders. Using observation, data collection, and caregiver interviews, the FBA examines antecedents, behaviors, and consequences to develop a hypothesis that guides the creation of an individualized Behavior Intervention Plan (BIP).
Applied Behavior Analysis	ABA is a scientifically supported model of treatment to remediate the functional impairments typically found in people with ASD. It is a time-limited treatment that should result in progressive measurable goals in function on a standardized measure.
Applied Behavior Analysis (ABA) Treatment	ABA treatment is an evidence-based behavioral health service that uses the principles of learning and behavior to teach new skills and reduce challenging behaviors. Treatment is individualized, data-driven, and may include direct 1:1 intervention, caregiver training, and support for skill generalization across home, school, and community settings. Services are delivered by qualified providers under the supervision of BCBA and must be clinically justified and medically necessary.

IV. PROCEDURES

A. Medical Necessity Criteria to Initiate Applied Behavioral Analysis

1. Services must be provided directly or billed by the appropriately licensed provider.

2. There have been demonstrations of functional impairment on a standardized scale of functioning in the past 12 months.

    a. For instance, the Vineland Adaptive Behavior Scales 3 (VABS-3), the Adaptive Behavior Assessment Scale (ABAS), Verbal Behavior – Milestones Assessment and Placement Program (VB-MAPP) or Assessment of Basic Language and Learning Skills (ABLLS).

3. The treatment plan documents have specific identified target behaviors and skills acquisition related to the condition, which are clearly defined i.e.,

    a. Frequency, rate, symptom intensity, duration, latency, or other objective measures of baseline levels are recorded, and quantifiable criteria for progress are established.

4. The treatment plan describes behavioral intervention techniques appropriate to the target behavior, reinforcers selected, and strategies for generalization of learned skills. Both the strategies and the objective criteria for generalization must be documented. The treatment plan must also include documentation of planning for transition through the continuum of interventions, services and settings, as well as titration and discharge criteria.

5. The level of impairment is used to justify the medical necessity for the number of hours requested. The table below provides guidance for providers to determine hours associated with behavior and severity.

Assessment of symptom severity (This can be used as a guide)				
	None	**Mild**	**Moderate**	**Severe**
Functional impairment	0 Hours/Wk	1 to 4 Hours/Wk	4 to 7 Hours/Wk	7 to 10 Hours/Wk
Maladaptive behavior: aggression, self-injury, property destruction, restrictive/repetitive behaviors and interests; abnormal, inflexible or intense preoccupations				

Social communication: Problems with expressive or receptive language, poor understanding or use of non-verbal communications, stereotyped or repetitive language, lack of social/emotional reciprocity, failure to seek or develop shared social activities				
Selfcare: Difficulty recognizing danger/risks, or advocating for self; problems with grooming/eating/toileting skills which are impeded by symptoms of autism				
Based on functional impairment and assessment of symptom severity, additional authorization may be provided for QHP protocol modification and direction at 1 to 2 hours per 10 hours of treatment by protocol, as well as authorization for caregiver training.				

6. The designated KHS reviewer (BCBA, MD-Psychiatry, Licensed Clinical Psychologist) following their review will make a determination, in accordance with the member's initial information submitted.

7. Authorization may be for up to 30 hours per week for Comprehensive ABA intervention (less than 2 years) or up to 25 hours per week for Focused ABA intervention for up to six (6) consecutive months unless sufficient clinical support justifies additional hours. Providers requesting more than 25 hours of ABA a week must include a clinical justification for enhanced ABA Care.

B. Medical necessity criteria to continue applied behavior analysis (ABA)

1. All the following criteria must be met:

   a. Medical necessity criteria are still met.
   b. Re-evaluation of interventions and progress has been performed (every six months) to assess the need for ongoing ABA, and,
   c. A repeated validated assessment (e.g., Vineland, ABAS, VB-MAPP, or ABLLS) must occur every 6months to demonstrate response to intervention.
   d. Target behaviors show improvement based on appropriate measurement methods (e.g., frequency, rate, duration, latency, intensity). If improvement is not observed, documentation must demonstrate that treatment has been modified, additional assessments have been completed, and/or consultations with relevant staff or experts have occurred.
   e. The treatment plan documents a gradual tapering of higher intensities of intervention and a shifting to supports from other sources (school, as an example) as progress occurs, and there is documentation of planning for transition through the continuum of interventions, services and settings, as well as titration and discharge criteria.

C. Termination of coverage of applied behavior analysis (ABA)

1. Termination:

    a. A member's progress is to be evaluated every six months.
    b. A member not making progress will be transitioned to other appropriate services.
    c. When it becomes clear that treatment is ineffective, or the treatment is no longer needed, this must be communicated to the family and provider.

2. Coverage of a service will end when one of the following criteria is met:

    a. Medical necessity is no longer met.
    b. The recipient shows improvement from baseline in targeted skill deficits and problematic behaviors such that goals are achieved or maximum benefit has been reached.
    c. If treatment exacerbates behavioral issues beyond expected short-term extinction bursts, the provider must conduct reassessment and submit justification before continuation.
    d. Progress toward treatment goals has plateaued without reasonable expectation of further improvement despite documented modifications to intervention.
    e. Recipients are unlikely to continue to benefit or maintain gains from continued care.
    f. The client does not demonstrate progress towards goals for successive authorization periods.

D. FBA Progress Report, and Other Documentation Requirements

1. FBA Requirement - A BCBA or QASP must complete an FBA including:

    a. Member demographics, referral reason, background, medical and school information, and current services.
    b. Clinical interview(s).
    c. Standardized assessments (e.g., VB-MAPP, ABLLS-R, AFLS, Vineland-3) based on age/presentation.
    d. Direct observations and ABC data.
    e. Risk assessment of maladaptive behaviors (frequency, intensity, risk of harm).
    f. Baseline skill and behavior levels, with mastery criteria.
    g. Individualized, measurable short-term, intermediate, and long-term goals.
    h. A treatment plan aligned with APL 23-010 requirements.
    i. Member availability for BHT services (considering school and family commitments).

    Note: Clinical justification is required if FBA exceeds 10 hours.

2. Progress Report & Treatment Plan

    a. The Provider must use evidence based BHT services in accordance with nationally recognized ABA guidelines and industry standards.
    b. The Treatment Plan must clearly identify and document the following:
        i. Service type(s).
        ii. Total number of direct care hours requested.

iii. Observation requirements.
iv. Direct service delivery and supervision.
v. Parent/guardian training, support and participation, aligned with requested S5111 units.
vi. The frequency of progress measurement and reporting for each BHT service and provider responsible for delivering the services.
vii. An individualized transition plan that is specific, measurable, and not copied/pasted.
viii. An individualized crisis plan (must not be copied/pasted)
ix. Care coordination must include the parent/guardian, with documentation of frequency and method of communication.
x. Care Coordination with schools to ensure services and goals are not duplicated.
xi. Care Coordination with other specialists (e.g., OT/ST/therapy) to ensure treatment integration.
xii. delivery in a home or community-based setting, otherwise clinically justified.

c. Service Requests for hours in daycare or school setting must include clinical justification.
d. ABA services must not assume to replace school-based services, which are the responsibility of the school.
e. Any school-based service must include written approval from the school and must and must remain proportionate to come and community hours.

3. Treatment Hour Requests

   a. All requests for treatment hours must be based on the results of the FBA, standardized assessments, and the members' individualized clinical needs.

4. Direct Intervention

   a. Clinical Care Guidelines state that most pediatric members will benefit up to 25 hours per week from ABA services.
   b. Requests of more than 25 hours per week require written clinical justification describing the need for enhanced ABA care.

5. Parent Training

   a. Limited to a maximum of two (2) sessions per day.
   b. Requests must clearly align with treatment goals and objectives documented in the treatment plan.

6. Requests for 2:1 Staffing

   a. May be considered when one or more non-redirectable destructive behaviors that pose a significant risk of harm are present, and when targeted interventions require increased staffing for safety and treatment integrity.

b. Requests must include behavioral risk description, treatment exposure plan, and safety procedures for high-risk settings:
   i. Description of the behaviors that pose a significant risk of harm.
   ii. Description of how the treatment plan will expose the member to social or environmental. stimuli associated with destructive behavior.
   iii. Description of how the assessment and intervention will be conducted in a setting. conducive to safety for the members and others present.
   iv. The total hours requested must be proportionate to treatment goals and overall hours.

E. Clinical Supervision and Case Management Activities

1. The amount of clinical supervision and case management for each case must be tailored to the individual client's needs. The following standards apply:

   a. General Standard of Care
   b. Direct Supervision
      i. Direct supervision may be requested at the rate of 2 hours for every 10 hours of direct 1:1 treatment.
      ii. H0032 may be used for a variety of supervision activities such as (not limited to):
         A. Assessment Updates
         B. Developing treatment goals
      iii. H0031 may be used at the beginning of services by a new provider.
   c. Indirect Supervision
      i. Indirect supervision may be requested for up to 10 hours per authorization.
      ii. Indirect supervision activities performed by a BCBA may include:
         A. In-office functional analysis and skills assessment.
         B. In-office development of goals/objectives and behavioral intervention plans/reports
         C. In-office direct staff summary notes
         D. In-office clinical meetings with both paraprofessionals and parents present
      iii. Indirect supervision must be billed on a separate line code from direct supervision.

2. Minimum Supervision Requirement

   a. When direct treatment is 10 hours per week or less, a minimum of 2 hours per week of clinical management and case supervision is generally required.

F. Documentation Requirements

1. The FBA report must:

   a. Summarize assessment results and risk evaluation.
   b. Identify domains of skill deficits and behavioral needs.
   c. Specify total recommended weekly hours and clinical rationale.
   d. Reference applicable nationally recognized Applied Behavior Analysis (ABA) guidelines and industry standards., or payer criteria.
   e. Document provider level(s) and modifiers (e.g., HO, HM) where applicable.

2. The calculated level of impairment substantiates the intensity and number of service hours requested.

G. Compliance

1. All staff must adhere to this policy to ensure accurate authorization requests and prevent payer claim denials.

2. Failure to comply may result in corrective action.

3. This policy aligns with:

   a. Nationally recognized Applied Behavior Analysis (ABA) guidelines and industry standards., or payer criteria.
   b. Failure to follow this policy may result in claim denials and corrective action.

V. ATTACHMENTS

Attachment A:	N/A

VI. REFERENCES

Reference Type	Specific Reference
All Plan Letter(s) (APL)	DHCS APL 23-010 Behavioral Health Treatment Responsibilities for Members under the Age of 21
Other	Behavior Analyst Certification Board, Inc (BCBA): Guidelines—Health Plan Coverage of Applied Behavior Analysis Treatment for Autism Spectrum Disorder (2012)
Regulatory	Diagnostic and Statistical Manual (DSM) V F. Title 22, California Code of Regulations (CCR), Sections 51184; 51242; 51340; 51532
Other	California Association for Behavior Analysis (CalABA): Report of the Task Force of California Association for Behavior Analysis—Guidelines for Applied Behavior Analysis (ABA) Services and Recommendations for Best Practices for Regional Center Consumers (March 2011)
Regulatory	CFR Title 42 § 440.130 Diagnostic, screening, preventive, and rehabilitative services.
Other	Counsel of Autism Service Providers (CASP) Applied Behavior Analysis Practice Guidelines for the Treatment of Autism Spectrum Disorder Guidance

	for Healthcare Funders, Regulatory Bodies, Service Providers, and Consumers
Regulatory	CFR Title 42 § 440.130 Diagnostic, screening, preventive, and rehabilitative services

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Effective	10/01/2025	New policy outlining the process for ABA medical necessity reviews.	Melinda Santiago

VIII. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		