Management of Applied Behavior Analysis (ABA)

About ABA Benefits

ABA is considered a covered benefit for:

- Fully Insured plans
- Federal Employee Program® (FEP®)
- Administrative Services Only (ASO) plans. ASO plans may request to "opt out" of ABA coverage.

Effective 1/1/2021, BCBSTX removed exclusions and limitations on ABA Therapy for Autism Spectrum Disorder (ASD) and it is now covered as standard claims administration subject to copays, coinsurance and deductible without age, dollar or visit limits. Contact the Behavioral Health (BH) Call Center at **1-800-528-7264** to check member benefits for all plans.

ABA will continue to be covered only for Autism Spectrum Disorder (ASD) diagnoses. All providers on behalf of the member are required to notify Blue Cross and Blue Shield of Texas (BCBSTX) of a request to provide ABA services for members.

ABA Prior Authorization

The initial prior authorization process will be used to confirm:

- Member has a confirmed autism diagnosis by an appropriate diagnostician;
- Provider is qualified to conduct ABA services;
- Member has benefit coverage for ABA services; *and*
- The initial treatment plan meets medical necessity.

As part of the initial prior authorization process, the provider must submit the requested ABA forms to confirm the above requested information:

- *ABA Clinical Service Request Form*
- *ABA Initial Assessment Request*

These forms (including specific forms for the Employee Retirement System of Texas and Teacher Retirement System of Texas) are available on the Forms page of the BCBSTX website or by calling the BH Call Center. The forms must be completed in their entirety for our clinicians to review the request. Failure to complete the forms could result in a decision delay. Once these forms are reviewed, a prior authorization letter is sent to the member and provider by mail to confirm or decline the service request. Once the initial prior authorization process has been completed, the provider may initiate ABA services for the member.

Concurrent Review Process

During each episode of authorized treatment, the BH Outpatient Management team may outreach to the provider to participate in the concurrent review process. If contacted, the provider is required to provide clinical

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justification for continued treatment through submission of the *ABA Clinical Service Request Form* and any additional medical records that might be requested by the BH Outpatient team.

If a claim is submitted without completion of the initial or concurrent prior authorization process, the provider and member will receive a denial notification. The provider will be directed to complete the required prior authorization process and a retroactive review may be required. The provider can contact the BH Outpatient Team at any time for clarification of the process at the BH Call Center.

All behavioral health benefits are subject to the terms and conditions as listed in the member's benefit plan

Please note that checking eligibility and benefits, and/or the fact that a service or treatment has been prior authorized or predetermined for benefits is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have questions, contact the number on the member's ID card.