Policy and Procedure

DEPARTMENT: Trillium Behavioral Health	**DOCUMENT NAME**: Applied Behavioral Analysis
PAGE: 1 of 9	**REPLACES:** NA
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PRODUCT TYPE: Medicaid and OHP	**REFERENCE NUMBER:** NA

A. Purpose

Trillium Behavioral Health (TBH) has written Utilization Management (UM) decision making clinical criteria to assist licensed UM staff make Applied Behavioral Analysis (ABA) pre-service decisions and to describe the Level of Care (LOC) service authorization process.

B. Policy

1. Clinical criteria for ABA services must be met including:

1.1. A written pre-service request submitted by a requesting provider including both:

1.1.1. Diagnosis by a licensed physician, psychologist, nurse practitioner specializing in developmental medicine, or a physician's assistant specializing in developmental medicine with experience and training in the diagnosis of Autism Spectrum Disorder (ASD) that includes evidence of:

1.1.1.1. A covered Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD) diagnosis listed on the ASD line of the Oregon Health Plan (OHP) Prioritized List.

1.1.2. The presence of behaviors which place the member at risk for harm or create significant daily issues related to care, education, or other important functions.

2. Service Intensity:

2.1. Recipients age one (1) through twelve (12) are eligible for intensive and less intensive interventions.

2.2. Recipients age thirteen (13) and older are eligible for less intensive services only.

2.3. Intensive interventions include therapies that address multiple behaviors at once,

are more comprehensive in nature, and often start at an earlier age.

2.3.1. Effective maximum of forty (40) hours per week.

2.3.1.1. If more units are requested than age range effective maximum, Medical Director review is required.

2.4. Less intensive interventions focus on a few targeted behaviors and generally are used with older children, with no need for intensive services.

2.4.1. Effective maximum of sixteen (16) hours per week, divided into daily, twice-daily or weekly sessions, over a period of several months.

2.4.1.1. If more units are requested than age range effective maximum, Medical Director review is required.

2.5. Intensive and less intensive interventions are based on medical appropriateness.

2.6. Services in excess of the above coverage guidelines, including intensive interventions for individuals aged thirteen (13) and older, will consider medical appropriateness, and:

2.6.1. Severity,

2.6.2. Depth and breadth of previous treatment,

2.6.3. How recently the diagnosis has been made,

2.6.4. Comorbidities such as psychiatric disorders, developmental delays, and intellectual disability which may make it harder to treat ASD and may require more intensity of treatment to be effective, and

2.6.5. Factors that would be contrary to the efficacy of ABA or increased intensity of ABA services.

3. ABA will be provided in an appropriate available treatment environment(s) characterized by:

3.1. The most normative,

3.2. Least restrictive,

3.3. Least intrusive,

3.4. Culturally and linguistically appropriate,

3.5. Evidenced based and/or evidence informed, and

3.6. Extent of family and community supports.

C. Procedure

1. Referrals:

1.1. Referred member must be enrolled in Trillium Community Health Plan.

1.3. Trillium members are able to access outpatient mental health assessments with an in-network provider without a referral.

1.4. If member is at immediate risk of acute medical care without intervention member is directed to medical services.

2. For services not requiring a prior authorization (PA) based on Authorization Required Qualifiers (ARQ), participating (par) provider is able to submit claims.

3. Non-participating (non-par) providers always require a PA based on ARQ prior to the first date of service.

4. Provider must submit:

4.1. PA request and service plan.

4.2. Diagnosis by a licensed physician, psychologist, nurse practitioner specializing in developmental medicine, or a physician's assistant specializing in developmental medicine, with experience and training in the diagnosis of ASD that includes evidence of all of the following:

4.2.1. A covered DSM and ICD diagnosis listed on the ASD line of the OHP Prioritized List,

4.2.2. Evidence that a parent or caregiver has been interviewed,

4.2.3. Evidence that a review of relevant medical records was conducted,

4.2.4. Evidence that the assessing practitioner was able to observe the member directly,

4.2.5. Documentation of and results from standardized, validated assessment tools that have been used to substantiate the ASD diagnosis and to document the developmental status of the member, and

4.2.6. Documentation of a comprehensive medical exam within the following parameters:

4.2.6.1. For children age one through six (1-6), a physical exam from the most recent well child care visit within one (1) year may be submitted.

4.2.6.2. For children age six through eighteen (6-18), a physical exam from the most recent well child care visit within two (2) years may be submitted.

4.2.7. A referral for ABA treatment, with or without specification of hours or intensity, including:

4.2.7.1. A covered DSM and ICD diagnosis listed on the ASD line of the OHP Prioritized List.

4.3. Updated behavioral health assessment or addendum information completed by Qualified Mental Health Professional (QMHP), within the previous six (6) months, including:

4.3.1. Sufficient biopsychosocial information to support the presence of a covered DSM and ICD diagnosis listed on the ASD line of the OHP Prioritized List.

4.4. Service Plan (updated at least every six (6) months and annually), requiring parental or caregiver participation including:

4.4.1. Assessment information,

4.4.2. Documentation of parent or caregiver, school, state disability programs, and others participation as applicable,

4.4.3. Anticipated outcomes stated as clear, directly observable, and continually measured goals,

4.4.4. Service intensity to be provided to include level of severity and associated hours, frequency and anticipated duration, and

4.4.5. Recommended individualized service and supports approved and overseen by:

4.4.5.1. A Board Certified Assistant Behavior Analyst (BCBA) or BCBA-D, or

4.4.5.2. A licensed health care professional with documented expertise and training in ABA.

4.4.6. Recommended individualized service and supports to be provided by:
4.4.6.1. A BCBA, or

4.4.6.2. A Behavioral Analysis Interventionist (BAI).

4.5. When available, the following documentation may also be included:
4.5.1. Notes from well-child visits or other medical professionals.

4.5.2. Results from additional assessments such as:
4.5.2.1. IQ tests,

4.5.2.2. Achievement tests,

4.5.2.3. Speech and language tests,

4.5.2.4. Assessments of adaptive functioning, and

4.5.2.5. Tests of auditory function, per these parameters:
4.5.2.5.1. Newborn hearing assessment, sufficient until the age of (24) months.

4.5.2.5.2. For children age two through 5 (2-5), a hearing exam must have been completed within previous one (1) year.

4.5.2.5.3. For children age six through 18 (6-18), a hearing exam must have been completed within previous two (2) years.

4.5.3. Any other pertinent supporting documentation.

5. TBH Licensed UM staff:
5.1. Determine clinical appropriateness and medical necessity of requested level of care for treatment, indicated by:
5.1.1. Review of clinical information submitted, including behavioral health assessment and pertinent medical documentation.

5.2. Refer member to an ABA provider to assess the member's needs, including service intensity, and develop service plan for the delivery of ABA services.

5.3. Refer to TBH Care Coordination (CC) staff when necessary to ensure the provision of care coordination, treatment engagement, preventative services, community-based services, and follow-up services for all members' health conditions.

6. Expected outcome and discharge planning to lower LOC considers the following factors:
6.1. Stabilization/improvement of symptoms,

6.2. Stabilization/improvement of daily functioning,

6.3. Prevention of higher LOC services, or

6.4. Less restrictive LOC services are determined to be clinically appropriate.

7. When request is approved:
7.1. An initial PA for ABA assessment will not exceed thirty (30) days and will be determined within fourteen (14) day pre-service timelines.

7.2. An initial PA for ABA services will not exceed six (6) months and will be determined within fourteen (14) day pre-service timelines.

7.3. A concurrent request for an extended or new date range or for additional codes or units within the current approved date range will be determined within fourteen (14) day pre-service timelines and is based on additional clinical justification demonstrating:

7.3.1. A reasonable expectation exists that the individual will benefit from the continuation of ABA services,

7.3.2. Demonstrated gains exceed those expected to arise from maturation alone,

7.3.3. Service plan updated within the past sixty (60) days including coordination of care and an expectation of parent/caregiver participation, as able, in treatment updated on a frequent basis,

7.3.4. Medical appropriateness for requested services and/or emergence of new problem behaviors, and

7.3.5. Demonstrated progress towards meaningful predefined objectives by use of a standardized, multimodal assessment approximately every six (6) months which can and may include:

7.3.5.1. Vineland,

7.3.5.2. IQ tests (Mullen, WPPSI, WISC-R),

7.3.5.3. Language measures,

7.3.5.4. Behavior checklists (CBCL, ABC), and

7.3.5.5. Autistic symptoms measures (SRS, ABAS-III, ADOS, ADI-R).

7.3.6. Treatment is not making the symptoms persistently worse.

8. When request is denied:

8.1. If the initial or concurrent review of the authorization request is determined not to meet criteria, practitioner is notified within determination timelines by TBH UM staff.

8.2. When the decision is to deny request, an expedited appeal may be requested if practitioner disagrees with the determination.

9. When request is returned to sender:

9.1. Upon review, the authorization is determined to be incomplete due to missing one or more of the following required components:

9.1.1. Member identifying information,

9.1.2. Requesting and Servicing Provider information (i.e. Tax ID number, National Provider Identifier (NPI) number), including:

9.1.2.1. Medicaid Provider/DMAP number for non-par outpatient service requests.

9.1.3. Start date and end date for services,

9.1.4. ICD diagnostic code(s),

9.1.5. Billing code(s), and

9.1.6. Number of units/visits/days for each billing code.

9.2. Upon review, no authorization is required per the ARQ for par providers.

9.3. Upon review, the member is ineligible for Trillium coverage for all dates of service requested.

9.4. Upon review, the request does not meet one of the following exceptions for acceptance of a retroactive request:

9.4.1. Catastrophic event that substantially interferes with normal business operations or a provider, or damage or destruction of the provider's business office or records by a natural disaster,

9.4.2. Mechanical or administrative delays or errors by the Contractor or State Office, or

9.4.3. Provider was unaware that the member was eligible for services at the time that services were rendered and the following conditions are met:

9.4.3.1. The provider's records document that the member refused or was physically unable to provide the Recipient Identification Number,

9.4.3.2. The provider can substantiate that he/she continually pursued reimbursement from the patient until eligibility was discovered, and

9.4.3.3. The provider submitted the request for authorization within sixty (60) days of the date the eligibility was discovered (excluding retro-eligibility).

9.5. Upon review, the member has Third Party Liability or other primary insurance. Via return to sender, provider is notified Trillium coverage is payer of last resort and no authorization is required to submit claims for dates of service also covered by primary insurance. If primary insurance denies service, Trillium authorization can be initiated with inclusion of evidence of primary insurance denial.

9.6. Prior to returning the request, two attempts will be made to obtain the missing information for Trillium Medicaid member requests and three attempts will be made to obtain the missing information for Medicare member requests**.**

D. Definitions

Word / Term	Definition
Applied Behavioral Analysis (ABA)	The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human social behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.
Adult	A person 18 years of age or older, or an emancipated minor. An individual with Medicaid eligibility, who is in need of services specific to children, adolescents, or young adults in transition, must be considered a child until age 21 for the purposes of these rules. Adults who are between the ages of 18 and 21, who are considered children for purposes of these rules, must have all rights afforded to adults as specified in these rules.
ARQ	Authorization Required Qualifier.
Autism Spectrum Disorder (ASD)	The meaning given that term in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V).
Autism	A developmental disability significantly affecting verbal and nonverbal communication and social interaction that adversely affects a child's educational performance. Other characteristics that may be associated with autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences. Essential features are typically but not necessarily manifested before age three. Autism may include autism spectrum disorders such as but not limited to autistic disorder, pervasive developmental disorder, not otherwise specified, and Asperger's syndrome. The term does not apply if a child's educational performance is adversely affected primarily because the child has an emotional disturbance. However, a child who qualifies

Word / Term	Definition
	for special education under the category of autism may also have an emotional disturbance as a secondary disability if the child meets the criteria under emotional disturbance.
Behavioral Analysis Interventionist (BAI)	A paraprofessional who practices under the close, ongoing supervision of a BCBA, BCaBA, and is primarily responsible for the direct implementation of behavior-analytic services. The BAI does not design intervention or assessment plans
Board Certified assistant Behavior Analyst (BCaBA)	An dependent practitioner with an undergraduate-level certification in behavior analysis. Certified BCaBAs may not practice independently, but must be supervised by someone certified at the BCBA/BCBA-D level. BCaBAs can supervise the work of BAIs, and others who implement behavior-analytic interventions.
Board Certified Behavior Analyst (BCBA or BCBA-D)	A board certified behavior analyst with a Masters or Doctoral Degree licensed by the Oregon Behavioral Analysis Regulatory Board with at least two (2) years of experience providing services to children with autism spectrum disorder (ASD).
Care Coordination (CC)	For members with primarily psychosocial issues such as housing, financial, etc. with need for referrals to community resources or assistance with accessing health care services. Typically non-clinical activities with assistance from clinical staff if minor medical or behavioral health concerns arise. Services include outreach to member, appointment scheduling assistance, securing authorizations assistance and follow up to ensure compliance.
Care Coordination (CC) Staff	Non-licensed UM staff.
Child	An individual under the age of eighteen (18). An Individual with Medicaid eligibility who is in need of services specific to children, adolescents, or young adults in transition is considered a child until age twenty-one (21).
Clinical Criteria	Written decision rules, medical protocols, or guidelines used as an element in evaluation of medical necessity and appropriateness of requested medical and behavioral health care services.
Diagnostic and Statistical Manual of Mental Disorders (DSM)	Standard classification of mental disorders used by mental health professionals in the United States, consisting of three major components: 1) Diagnostic classification; 2) Diagnostic criteria sets; 3) Descriptive text.
ICD	The International Classification of Diseases.
Licensed Health Care Professional	An individual whose scope of practice includes applied behavior analysis who is licensed by: (a) The Occupational Therapy Licensing Board; (b) The Oregon Board of Licensed Professional Counselors and Therapists; (c) The Oregon Medical Board; (d) The Oregon State Board of Nursing; (e) The Physical Therapist Licensing Board; (f) The State Board of Examiners for Speech-Language Pathology and Audiology; (g) The State Board of Licensed Social Workers; or (h) The State Board of Psychologist Examiners.
Licensed UM Staff	Licensed Behavioral Health UM staff are: • Behavioral Health Care Coordinators (QMHPs), Doctoral-level clinical psychologists, and psychiatrists.
Medically Appropriate	Services and medical supplies required for prevention, diagnosis or treatment of a physical or mental health condition, or injuries, and which are: (a) Consistent with the symptoms of a health condition or treatment of a health condition; (b) Appropriate with regard to

Word / Term	Definition
	standards of good health practice and generally recognized by the relevant scientific community and professional standards of care as effective; (c) Not solely for the convenience of an individual or a provider of the service or medical supplies; and (d) The most cost effective of the alternative levels of medical services or medical supplies that can be safely provided to an individual.
Mental Health Assessment	The process of obtaining sufficient information, through a face-to-face interview to determine a diagnosis and to plan individualized services and supports.
Non-Participating Provider	A provider that does not have a contractual relationship with Trillium and is not on their panel of providers.
Oregon Health Plan (OHP)	In Oregon, the Medicaid Program is called OHP.
Participating Provider	A physician, hospital or other licensed healthcare facility or licensed healthcare professional duly licensed in the State of Oregon, credentialed in accordance with Trillium's policies and procedures, who has entered into an agreement with Trillium to provide covered services to members.
Post Service Decision	Assessing appropriateness of behavioral health services on a case-by-case or aggregate basis after services were provided. Retro authorization and claims payment requests are post service decisions.
Pre-service Decision	Any care or service TBH must approve, in whole or in part, in advance of the member obtaining behavioral healthcare or services. Pre-authorization and pre-certification are pre-service decisions.
Prior Authorization (PA)	Prior assessment that proposed services are appropriate for a particular patient and will be covered by TBH. Payment for services depends on whether member and category of service are covered by member's benefit plan.
Service Intensity	Interventions to therapies that address multiple behaviors at once, are more comprehensive in nature, and often start at an earlier age; or focus on a few targeted behaviors and generally are used with older children, younger children, and adults with no need for intensive services.
Service Plan	A comprehensive plan for services and supports provided to or coordinated for an individual and his or her family, as applicable, that is reflective of the assessment and the intended outcomes of service.
Utilization Management (UM)	Evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed clinical assistance to patient, in cooperation with other parties, to ensure appropriate use of resources.
Utilization Management (UM) Staff	Licensed or Non-licensed UM staff.

E. Regulatory or Administrative Citations

Name	Citation Reference
CCO and OHP 2018 Contract	Provision of Covered Service
	B.2.2.c.(1-6)d.
	Authorization or Denial of Covered Services
	B.2.3.
	Integration and Care Coordination
	B.4.1

	Delivery System and Provider Capacity
	B.4.3.a.3
Health Evidence Review Commission	Guideline Note 75
Current NCQA Health Plan Standards and Guidelines	UM 2: C Clinical Criteria for UM Decisions
	UM 4: A, B, D, F, G Appropriate Professionals
	UM 5: C, D Timeliness of UM Decisions
	UM 6: B Relevant Information for Behavioral Health Decisions
	UM 7: D, E, F Denial Notices
Oregon Administrative Rules	410-120-1295
	410.172.0650
	410.172.0760
	410.172.0770
Oregon Regulatory Statutes	743A.190
	Chapter 771

F. Related Material

Name	Location
Use of Out-of-Network Providers and Steerage Policy	Trillium Database

G. Revision Log

Type	Date
Merged Policy and Procedure into one document.	12-11-17
Added Return to Sender language	1-8-18
Updated Definition List	1-8-18
Updated OAR Citations	1-8-18
Removed Senate Bill from Section E due to redundancy	1-8-18
Added CCO and OHA Contract Citations	2-6-18
Updated Initial and Concurrent Authorization language	11-8-18
Updated Definitions	2-4-19
Updated OARS	2-4-19
Updated Related Material	2-4-19
Updated Return to Sender Language	2-4-19