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Medical Necessity Guidelines for Applied Behavioral Analysis: Clinical Workgroup Update

January 2016

Clinical Workgroup Task

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Selected clinical workgroup participants are assisting in the development of medical necessity guidelines clarifying the authorization pathway for Behavioral Health Rehabilitation Services, including Applied Behavioral Analysis (ABA), for children and adolescents under age 21 diagnosed with Autism Spectrum Disorder (ASD).

Medically Necessary in PA Code

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Title 55 PA Code Section 1101.21a clarifies “medically necessary” for Pennsylvania Medical Assistance. The workgroup’s scope did not include changes to this definition.

“A service, item, procedure or level of care that is necessary for the proper treatment or management of an illness, injury or disability is one that:

1. “Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.

2. “Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

3. “Will assist the recipient to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and those functional capacities that are appropriate of recipients of the same age.”

Behavioral Health Rehabilitation Services

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The term Behavioral Health Rehabilitation Services (BHRS) for children and adolescents refers to a range of medically necessary, off-site (e.g., out-of-clinic), community-based services for children with behavioral and mental health needs, up to age 21.

- BHRS in Pennsylvania emanates from the Commonwealth's implementation of OBRA 89, federal legislation from 1989.

- BHRS as a service designation encompasses a broad range of individualized services for the child, developed in response to the individualized needs of children and their families.

Current landscape for treatment of ASD in Pennsylvania:

- Research has established treatment approaches designed to address the social, behavioral and communication deficits related to ASD can help to ameliorate the overall impact of the disorder.

In Pennsylvania, ABA can be delivered through the following BHR services:

- Behavioral Specialist Consultant-ASD (Doctoral Level)
- Behavioral Specialist Consultant-ASD (Master's Level)
- Therapeutic Staff Support

The workgroup’s scope was to recommend changes to medical necessity guidelines for these existing services.

Clinical Workgroup Participants

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- Rayni Anderson Brindley, NHS Human Services
- Dr. Nathan Blum, The Children's Hospital of Philadelphia
- Dr. Tiberiu Bodea Crisan, University of Pittsburgh Medical Center
- Michelle Brogna, PerformCare
- Dr. Anne Deaner, Community Behavioral Health
- Dr. Charma Dudley, ValueOptions
- Kelly Griess, Magellan Behavioral Health of Pennsylvania
- Dr. Todd Harris, Devereux
- Dr. John McGonigle, University of Pittsburgh Medical Center
- Dr. Michael Murray, Penn State University
- Claire Ryder, Community Behavioral Health
- Sherry Shaffer, Community Care Behavioral Health
- Michele Slowik, Exceptional Connections

- Truven Health Analytics is providing facilitation support

Workgroup Process

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- First meeting (August 27) – developed initial key concepts for recommended medical necessity guidelines based on the goals of ABA
- Second meeting (September 29) – refined key concepts, informed by examples from other states and plans provided by workgroup members. The refined key concepts will be summarized later in this presentation
- Stakeholder meetings (November 23 through January 8) – OMHSAS discussion of key concepts with stakeholders

Workgroup Process

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- Third meeting (December 8) – the workgroup reviewed key concepts and stakeholder input. OMHSAS presented a framework for draft medical necessity guidelines and the group provided feedback on that framework

- January conference call – the workgroup will have a conference call in mid-January to incorporate feedback from the last stakeholder meeting.

- OMHSAS will revise guidelines based on the workgroup's recommendations and solicit feedback from the workgroup and stakeholders.

Structure for Key Concepts

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Consistent with other services, the key concepts are organized based on three stages of treatment:

I. Admission

II. Continued Care

III. Discharge

**** This slide shows draft key concepts for guidelines from an external clinical workgroup.***

Draft Concepts for Admission

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I. Services should address skill deficits that interfere with life in the home or community as well as address observed challenging behaviors.

The workgroup reviewed the requirements needed to initiate treatment, including:

1. Diagnosis
2. Comprehensive Assessment
3. Treatment Plan

Suggestions made it clear that any necessary requirements should be able to occur in a manner that avoids any unnecessary delay initiating treatment.

For example, the treatment team could convene to discuss the findings of the evaluation to develop an initial treatment plan even when a provisional diagnosis is rendered.

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Draft Concepts for Admission

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- If necessary, initial treatment recommendations could include a more comprehensive assessment to confirm the diagnosis.
- Workgroup members also discussed the merits of having a comprehensive assessment completed prior to the initiation of treatment, including an assessment of skill deficits and behavioral indicators.
- Examples of skill deficits or behavioral indicators that could lead to treatment include:
  - Non-verbal or limited functional communication or pragmatic language
  - Impairment in social interaction, social reasoning, social reciprocity, and interpersonal relatedness
  - Behavioral dysregulation including internalizing behaviors, elopement, and self-stimulatory behaviors
  - Behaviors that interfere with optimal functioning in home, school, work, and/or community settings.

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Draft Concepts for Admission

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1. Diagnosis

   – Must be by a licensed physician or psychologist, preferably one with expertise in children and youth or in ASD

   – The diagnosis should be defined in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (currently DSM-5)

      • Workgroup members discussed requiring the use of validated, standardized screening tools such as the Social Responsiveness Scale (SRS) during the diagnostic evaluation process

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Draft Concepts for Admission

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2. Comprehensive Assessment

- The comprehensive assessment provides data to inform the treatment plan. It can include a functional behavioral assessment and medical and developmental history.
- The comprehensive assessment provides information to the physician or psychologist, which can confirm a provisional diagnosis
- An initial treatment plan may be developed even if other portions of the comprehensive assessment are in process
- Significant collaboration of the interagency team should occur during assessment

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Workgroup Recommendations for Comprehensive Assessment (cont.)

- The comprehensive assessment includes other medical and developmental information such as:
  - Adaptive and cognitive skills assessment (such as VB-MAPP, ABLLS, AFLS, or Essentials for Living)
  - Medical history
  - Vision and hearing screening
  - A validated, standardized assessment tool for ASD diagnosis (such as the ADOS) if the ASD diagnosis is uncertain

- The comprehensive assessment informs the treatment plan. If treatment starts before the assessment is complete, the treatment plan may change as more information is learned.

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Draft Concepts for Admission

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3. Workgroup Recommendations for Treatment Plan Development

– The initial treatment plan should include:

- Specific skill deficits and behaviors to be addressed and their frequency and duration
- The behavioral intervention techniques based on the function of the skill deficit or behavior
- Measurable, objective long-term and short-term goals for these skills and behaviors
- Baseline measures for the goals
- Methods for training parents, guardians, and other caregivers
- Strategies for generalizing learned skills to multiple environments
- A plan to fade services over time
- A discharge plan
- Anticipated timelines for meeting the goals, fading, and discharge

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Draft Concepts for Admission

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Additional Workgroup Recommendations to Consider for Admission Guidelines:

- Services must be appropriate to the child's needs
- The parent or guardian or youth age 14 or older must consent to treatment
- Parent or guardian involvement in treatment, including receipt of training from the person providing BSC services and implementation of treatment plan strategies

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II. Workgroup Recommendations for Continued Care

- The guidelines for admission continue to be met
- The comprehensive assessment must be completed at least annually. It may be completed more frequently if necessary based on a change in the child's needs.
- The provider should submit quarterly summaries to support continued treatment or document reasons for changes in treatment:
  - Updates to the information required for the treatment plan
  - A summary of data for the long-term and short-term goals in the treatment plan to show the progress of current treatment

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Draft Concepts for Continued Care

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Recommendations for Quarterly Summaries (cont.)

- Adjustments to the treatment plan based on data, such as:
  - A new goal to replace one that has been met
  - A change in skill development techniques and/or behavioral intervention when a child is not progressing
  - An attempt to fade supports so a child maintains function with less assistance
- Documentation of increased proficiency in supporting the child by parents, guardians, and other caregivers trained as part of treatment
- Documentation of attempts by the person providing BSC services to ensure treatment is consistent with other services such as medical care, education, and early intervention
- A plan for maintenance of skills acquired during treatment

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Draft Concepts for Discharge

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III. Workgroup Recommendations for Discontinuing Treatment

- Treatment plans, including the initial plan, should include a plan to fade supports over time until discharge
- The fade plan and discharge criteria may include an expectation that parents, guardians, and other caregivers will implement behavioral interventions after discharge
- Discharge should occur if the conditions for continued care are no longer met, including:
  - The parents or guardians refuse to participate in treatment
  - The child's needs can be met without treatment or with less intensive services because the skill deficits and behavioral indicators that required treatment have been addressed

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