INTRODUCTION

The Level of Care Guidelines is a set of objective and evidence-based behavioral health criteria used by medical necessity plans to standardize coverage determinations, promote evidence-based practices, and support members’ recovery, resiliency, and wellbeing for behavioral health benefit plans that are managed by Optum and U.S. Behavioral Health Plan, California (doing business as OptumHealth Behavioral Solutions of California (“Optum-CA”)).

INSTRUCTIONS FOR USE

This guideline is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning for behavioral health benefit plans managed by Optum®.¹ When deciding coverage, the member’s specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member’s benefits prior to using this guideline. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this guideline and the member’s specific benefit, the member’s specific benefit supersedes this guideline. Other clinical criteria may apply.

Optum reserves the right, in its sole discretion, to modify its clinical criteria as necessary using the process described in Clinical Criteria.

This guideline is provided for informational purposes. It does not constitute medical advice.

Optum may also use tools developed by third parties that are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Optum may develop clinical criteria or adopt externally-developed clinical criteria that supersede this guideline when required to do so by contract or regulation.

COMMON CRITERIA

Admission Criteria

- The member’s current condition cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive level of care.

¹ Optum is a brand used by United Behavioral Health and its affiliates.
o Failure of treatment in a less intensive level of care is not a prerequisite for authorizing coverage.

o The member’s condition includes consideration of the acute and chronic symptoms in the member’s history and presentation including co-occurring behavioral health or medical conditions, informed by the information collected by the provider following evaluation and treatment planning described in the Common Best Practices.

AND

• The member’s condition can be safely, efficiently, and effectively assessed and/or treated in the proposed level of care. Assessment and/or treatment of the member’s condition require the intensity and scope of services provided in the proposed level of care.

AND

• Co-occurring behavioral health and medical conditions can be safely managed in the proposed level of care.

AND

• Services are medically necessary.

AND

• For all levels of care, services must be for the purpose of diagnostic study or reasonably be expected to improve the patient’s condition. The treatment must, at a minimum, be designed to reduce or control the patient’s psychiatric symptoms so as to prevent relapse or hospitalization, and improve or maintain the patient’s level of functioning.

    o It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some patient. For many other psychiatric patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion is met.

    o In addition to the above, for outpatient services, some patients may undergo a course of treatment that increases their level of functioning but then reach a point where further significant increase is not expected. Such claims are not automatically considered noncovered because conditions have stabilized, or because treatment is now primarily for the purpose of maintaining a present level of functioning. Rather, coverage depends on whether the criteria discussed above are met; for example, that stability can be maintained without further treatment or with less intensive treatment.

Continuing Stay Criteria

• The admission criteria continue to be met and active treatment is being provided. For treatment to be considered “active”, service(s) must be as follows:

    o Supervised and evaluated by the admitting provider;

    o Provided under an individualized treatment plan consistent with Common Clinical Best Practices;

    o Reasonably expected to improve the member’s presenting problems.

AND

• The factors leading to admission have been identified and are integrated into the treatment and discharge plans.

AND

• Clinical best practices are being provided with sufficient intensity to address the member’s treatment needs.

AND

• The member’s family and other natural resources are engaged to participate in the member’s treatment as clinically indicated and feasible.

Discharge Criteria

• The continued stay criteria are no longer met. Examples include:

    o The member’s condition no longer requires care.

    o The member’s condition has changed to the extent that the condition now meets admission criteria for another level of care.
- Treatment is primarily for the purpose of providing social, custodial, recreational, or respite care.
- The member requires medical/surgical treatment.
- After an initial assessment the member is unwilling or unable to participate in treatment despite motivational support or intervention to engage in treatment, and involuntary treatment or guardianship is not being pursued.

**COMMON CLINICAL BEST PRACTICES**

**Introduction**

In assessing whether the criteria set forth in these guidelines is satisfied, staff should consider the clinical information collected from the provider following evaluation and treatment planning described in Common Clinical Best Practices. Staff should update the clinical information through continued consultation with the provider at appropriate intervals as the treatment progresses, including information about new or different symptoms or conditions that may emerge in the course of treatment.

**Evaluation & Treatment Planning**

- **The initial evaluation:**
  - Gathers information about the presenting issues from the member’s perspective, and includes the member’s understanding of the factors that lead to requesting services;
  - Focuses on the member’s specific needs;
  - Identifies the member’s goals and expectations;
  - Is completed in a timeframe commensurate with the member’s needs, or otherwise in accordance with clinical best practices.

- **The provider collects information form the member and other sources, and completes an initial evaluation of the following:**
  - The member’s chief complaint;
  - The history of the presenting illness;
  - The factors leading to the request for service;
  - The member’s mental status;
  - The member’s current level of functioning;
  - Urgent needs, including those related to the risk of harm to self, others, and/or property;
  - The member’s use of alcohol, tobacco, or drugs;
  - Co-occurring behavioral health and physical conditions;
  - The member’s history of behavioral health services;
  - The member’s history of trauma;
  - The member’s medical history and current physical health status;
  - The member’s developmental history;
  - Pertinent current and historical life information;
  - The member’s strengths;
  - Barriers to care;
  - The member’s instructions for treatment, or appointment of a representative to make decisions about treatment;
  - The member’s broader recovery, resiliency, and wellbeing goals.

- **The provider uses the findings of the evaluation to assign a DSM-ICD diagnosis.**

- **The provider and, whenever possible, the member use the findings of the initial evaluation and diagnosis to develop a treatment plan.** The treatment plan addresses the following:
  - The short- and long-term goals of treatment;
  - The type, amount, frequency, and duration of treatment;
  - The expected outcome for each problem to be addressed expressed in terms that are measurable, functional, time-framed, and related to the factors leading to admission;
  - How the member’s family and other natural resources will participate in treatment when clinically indicated;
  - How treatment will be coordinated with other provider(s), as well as with agencies or programs with which the member is involved.

- **As needed, the treatment plan also includes interventions that enhance the member’s motivation, promote informed decisions, and support the member’s recovery, resiliency, and wellbeing. Examples include psychoeducation, motivational interviewing, recovery and resiliency planning, advance directive planning, and facilitating involvement with self-help and wraparound services.**
• The provider informs the member of safe and effective treatment alternatives, as well as the potential risks and benefits of the proposed treatment. The member gives informed consent acknowledging willingness and ability to participate in treatment and abide by safety precautions.
• Treatment focuses on the member's condition including the factors precipitating admission to the point that the member's condition can be safely, efficiently, and effectively treated in a less intensive level of care, or the member no longer requires care.
• The treatment plan and level of care are reassessed when the member's condition improves, worsens, or does not respond to treatment.
  o When the member's condition has improved, the provider determines if the treatment plan should be altered, or if treatment is no longer required.
  o When the member's condition has worsened or not responded to treatment, the provider verifies the diagnosis, alters the treatment plan, or determines if the member's condition should be treated in another level of care.
• In the event that all information is unavailable at the time of the evaluation, there must be enough information to provide a basis for the diagnosis, guide the development of the treatment plan, and support the need for treatment in the proposed level of care.

Discharge Planning
• The provider and, whenever possible, the member develops an initial discharge plan at the time of admission, and estimates the length of treatment.
• The provider and, whenever possible, the member updates the initial discharge plan during the admission, ensuring that:
  o An appropriate discharge plan is in place prior to discharge;
  o The discharge plan is designed to mitigate the risk that the factors precipitating admission will reoccur;
  o The member agrees with the discharge plan.
• For members continuing treatment:
  o The discharge plan includes the following:
    • The discharge date;
    • The post-discharge level of care, and the recommended forms and frequency of treatment;
    • The name(s) of the provider(s) who will deliver treatment;
    • The date of the first appointment, including the date of the first medication management visit;
    • The name, dose, and frequency of each medication, with a prescription sufficient to last until the first medication management visit;
    • An appointment for necessary lab tests;
    • Resources to assist the member with overcoming barriers to care, such as lack of transportation or child care;
    • Recommended self-help and community support services;
    • Information about what the member should do in the event of a crisis prior to the first appointment.
• For members not continuing treatment:
  o The discharge plan includes the following:
    • The discharge date;
    • Recommended self-help and community support services;
    • Information about what the member should do in the event of a crisis or to resume services.
• The provider explains the risk of discontinuing treatment when the member refuses treatment or repeatedly does not adhere with the treatment plan.
ABA is a scientific discipline among the helping professions that focuses on the analysis, design, implementation, and evaluation of social and other environmental modifications to produce meaningful changes in human behavior. ABA includes the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. ABA uses changes in environmental events, including antecedent stimuli and consequences, to produce practical and significant changes in behavior. These relevant environmental events are usually identified through a variety of specialized assessment methods. ABA is based on the fact that an individual’s behavior is determined by past and current environmental events in conjunction with organic variables such as their genetic endowment and physiological variables. Thus, when applied to ASD, ABA focuses on treating the problems of the disorder by altering the individual’s social and learning environments. (Behavior Analyst Certification Board Inc., 2014).

For Medi-Cal members, Applied Behavior Analysis (ABA) is covered for the treatment of developmental disorders not limited to Autism Spectrum Disorder in children when the following conditions are met:

- The intervention is a systematic approach, based on the principles of comprehensive applied behavior analysis.
- Medically necessary to correct or ameliorate behavioral conditions as defined in Section 1905(r) of the SSA and as determined by a licensed physician and surgeon or licensed psychologist.\(^2\)
- Delivered in accordance with the member’s Managed Care Health Plan (MCP)-approved behavioral treatment plan.
- Provided by California State Plan approved providers defined in SPA 14-026.9\(^3\)
  - Board Certified Behavior Analyst (BCBA)
  - Licensed Practitioner
  - Associate Behavior Analyst
  - Behavior Analyst
  - Behavior Management Assistant
  - Behavior Management Consultant
  - Paraprofessional
- Provided and supervised according to an MCP-approved behavioral treatment plan developed by a Behavioral Health Treatment (BHT) service provider credentialed as specified in SPA 14-026 (“BHT Service Provider”).

**Diagnostic and Treatment Criteria**

See **Common Criteria** and the following:

**Diagnostic Evaluation**

In order to be eligible for services, a Medi-Cal member must meet all of the following coverage criteria:

- Be under 21 years of age.
- Have a recommendation from a licensed physician and surgeon or a licensed psychologist that evidence-based BHT services are medically necessary.
- Be medically stable.

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\(^2\) Necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan https://www.ssa.gov/OPP_Home/ssact/title19/1905.htm

\(^3\) http://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA14026.pdf
• Be without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID).

• Comprehensive diagnostic evaluations should occur including psychiatric assessments, interviews, review of records, psychological, and communication assessments.

**Treatment Planning**

Once the developmental disorder diagnosis has been established:

• A standardized functional assessment is used to maximize the effectiveness and efficiency of behavioral support interventions (Myers and Johnson, reaffirmed 2014). The assessment may incorporate information such as interviews with caregivers, structured rating scales, direct observation data, and attention to coexisting medical conditions (Behavior Analyst Certification Board, 2014)

• Targets include areas such as the following:
  o Communication skills
  o Language skills
  o Social interaction skills
  o Restricted, repetitive patterns of behavior, interests, or activities
  o Self-injurious, violent, destructive or other maladaptive behavior

• A credentialed provider with ABA expertise is identified to provide treatment. Examples include (e.g., Behavior Analyst Certification Board, 2014):
  o A Master- or Doctoral-level provider that is a Board Certified Behavior Analyst (BCBA)
  o A licensed behavioral health clinician who has attested to having sufficient expertise and has been credentialed to provide ABA services
  o A Board Certified Assistant Behavior Analyst (BCaBA) or non-licensed individual under the direct supervision of a BCBA or licensed behavioral health clinician who takes responsibility for the member’s care that does either of the following:
    ▪ Assist in the initial or concurrent assessment of the member’s deficits or adaptive behaviors
    ▪ Implement a treatment plan that has been developed by a BCBA or licensed behavioral health clinician
  o Paraprofessional interventions must be directly supervised with the child present at least 1 hour per month, up to 8 hours per month, not to exceed 1 hour for every 10 hours of direct care provided

• Outcome-oriented interventions targeting specific baseline behaviors are identified in a treatment plan describing the frequency, intensity, duration and progress that will be continuously updated.
  o Treatment planning a minimum of 1 hour per month up to 8 hours per month (not to exceed 1 hour for every 10 hours of direct service).
  o The treatment plan must address how the parents/guardians will be trained in management skills that can be generalized to the home.
    ▪ Parent/guardian training is an expectation. In the rare circumstance that parent/guardian is unable the documentation must reflect the reason and identify an alternate plan to provide management skills in the home.
    ▪ The treatment goals and objectives must be comprehensive and clearly stated.
- The treatment plan is in sync with the child’s Individual Family Service Plan (IFSP) / Individualized Education Plan (IEP).

- All components of the child’s care are tracked and updated throughout the duration of services.

**Treatment**

- Interventions must include the following elements:
  - Mitigate the core features of ASD or other developmental disorders
  - Target specific deficits related to imitation, attention, motivation, compliance and initiation of interaction, and the specific behaviors that are to be incrementally taught and positively reinforced
  - Tie to objective and quantifiable treatment goals that have projected timeframes for completion
  - Include the child’s parents in parent training and the acquisition of skills in behavior modification to promote management of skills within the home
  - Train family members and other caregivers to manage problem behavior and interact with the child in a therapeutic manner
  - As indicated, include psychotherapy (e.g., cognitive behavioral therapy) for higher functioning children to treat conditions such as anxiety and anger management

- Have an appropriate level of intensity and duration driven by factors such as:
  - Treatment goals
  - Changes in the targeted behavior(s) / response to treatment
  - The demonstration and maintenance of management skills by the parents and caregivers;
  - Whether specific issues are being treated in a less intensive group format (e.g., social skills groups) by the child in a therapeutic manner
  - The child’s ability to participate in ABA given attendance at school, daycare or other treatment settings
  - The impact of co-occurring behavioral or medical conditions on skill attainment

- Parent/Caregiver support is expected to be a component of the ABA program, as they will need to provide additional hours of behavioral interventions. Parents or caregivers must be involved and engaged in the training and follow through on treatment recommendations beyond that provided by licensed or certified practitioners. Parent support groups are considered not medically necessary.

- Services are intensive and may be provided daily, but ordinarily will not exceed 8 hours per day or 40 hours per week inclusive of other interventions. These hours of service also take into account other non-behavioral services such as school, speech, and occupational therapies, generally covered by other entities.

**Coordination of Care**

If applicable, documentation of communication and coordination with other service providers and agencies, (i.e. day care, preschool, school, early intervention services providers) and/or other allied health care providers (i.e. occupational therapy, speech therapy, physical therapy and any other applicable providers) to reduce the likelihood of unnecessary duplication of services. Documentation should include the following:

- Types of therapy provided
- Number of therapies per week
- Behaviors/deficits targeted
• Progress related to the treatment/services being provided
• Measureable criteria for completing treatment with projected plan for continued care after discharge from ABA therapy
• Total number of days per week and hours per day of direct services to child and parents or caregivers to include duration and location of requested ABA therapy
• Dates of service requested
• Licensure, certification and credentials of the professionals providing ABA services to the child
• Evidence that parents and/or caregivers have remained engaged in the treatment plan, following all appropriate treatment recommendations
  o Detailed description of interventions with the parent(s) or caregiver(s), including:
    ▪ Parental or caregiver education, training, coaching and support
    ▪ Overall parent or caregiver goals including a brief summary of progress. As part of the summary of progress the information should also include percentage of planned sessions attended
    ▪ Plan for transitioning ABA interventions identified for the child to the parents or caregivers

Continued Treatment Criteria
See Common Criteria and the following:
• With each medical necessity review for continued ABA treatment, an updated treatment plan and progress reports will be required for review, including all of the following documentation:
  o There is a reasonable expectation on the part of the treating clinician that the child’s behavior and skill deficits will continue to improve to a clinically meaningful extent, in at least two settings (home, school, community) with ABA services
  o Therapy is not making the symptoms or behaviors persistently worse
  o Progress is assessed and documented for each targeted symptom and behavior, including progress toward defined goals, and including the same modes of measurement that were utilized for baseline measurements of specific symptoms and behaviors.
  o The treatment plan and progress report should reflect improvement from baseline in skill deficits and problematic behaviors using validated assessments of adaptive functioning.
  o When there has been inadequate progress with targeted symptoms or behaviors, or no demonstrable progress within a six month period, or specific goals have not been achieved within the estimated timeframes, there should be an assessment of the reasons for inadequate progress or not meeting the goals, and treatment interventions should be modified or changed in order to attempt to achieve adequate progress. Documentation of such an assessment and subsequent treatment plan change(s) must include:
    ▪ Increased time and/or frequency working on targets
    ▪ Change in treatment techniques
    ▪ Increased parent/caregiver training
    ▪ Identification and resolution of barriers to treatment effectiveness
    ▪ Any newly identified co-existing disorder (e.g., anxiety, psychotic disorder, mood disorder)
• Goals reconsidered (e.g., modified or removed)
  o When goals have been achieved, either new goals should be identified that are based
    on targeted symptoms and behaviors that are preventing the child from adequately
    participating in age-appropriate home, school or community activities, or that are
    presenting a safety risk to self, others, or property; or, the treatment plan should be
    revised to include a transition to less intensive interventions.

Discharge Criteria
See Common Criteria and the following:

When any of the following criteria are met the child will be considered discharged and any
further ABA services will be considered not medically necessary:

• Documentation that the child demonstrates improvement from baseline in targeted skill
deficits and behaviors to the extent that goals are achieved or maximum benefit has been
reached

• Documentation that there has been no clinically significant progress or measurable
improvement for a period of at least 3 months in the child’s behaviors or skill deficits in
any of the following measures:
  o Adaptive functioning
  o Communication skills
  o Language skills
  o Social skills

• The treatment is making the skill deficits and/or behaviors persistently worse

• The child is unlikely to continue to benefit or maintain long term gains from continued ABA
  therapy

• Parents and/or caregivers have refused treatment recommendations or are unable to
  participate in the treatment program and/or do not follow through on treatment
  recommendations to an extent that is needed.

REFERENCES

California Guidance
State of California Health and Human Services, Responsibilities for Behavioral Health Treatment
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-
006.pdf

Common Criteria and Common Clinical Best Practices
American Association of Community Psychiatrists. Child and adolescent level of care utilization system
(CALOCUS) 2010.
American Association of Community Psychiatrists. Level of care utilization system (LOCUS) for
psychiatric and addiction services: Adult version 2010.
American Psychiatric Association. Practice guidelines for the psychiatric evaluation of adults (3rd ed.)
American Psychiatric Association. Practice guideline for the assessment and treatment of patients with
Centers for Medicare and Medicaid Services. Benefit policy manual, chapter 2 – inpatient psychiatric
Guidance/Guidance/Manuals/Internet-Only-Manuals-1OMs-
Items/CMS012673.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending


**Related Policies and Guidelines**


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