LEVEL OF CARE GUIDELINES: INTENSIVE BEHAVIORAL THERAPY / APPLIED BEHAVIOR ANALYSIS FOR AUTISM SPECTRUM DISORDER – HAWAII MEDICAID QUEST

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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®. 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. 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.

INTENSIVE BEHAVIOR THERAPY / APPLIED BEHAVIOR THERAPY

INTENSIVE BEHAVIOR THERAPY / APPLIED BEHAVIOR THERAPY is a reliable, evidence-based behavior intervention program designed to develop or restore the functioning of an individual diagnosed with Autism Spectrum Disorder.

The course of IBT is focused on addressing the factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the factors that precipitated treatment no longer require treatment.

1 Optum is a brand used by United Behavioral Health and its affiliates.
The service is not Long-Term Services and Supports (LTSS), Home and Community Based Services (HCBS), or Respite Services.

1. Admission Criteria
   • see "Common Criteria and Best Practices for All Levels of Care":
   AND
   • The member’ current signs and symptoms meet criteria for Autism Spectrum Disorder, or Autism Spectrum Disorder is provisionally diagnosed.
     o In the event that the member is provisionally diagnosed with Autism Spectrum Disorder, the member may qualify for up to a 26-week trial of Applied Behavior Analysis when the criteria in this guideline are otherwise met.
   AND
   • Services are medically necessary
   AND
   • Treatment is not covered when any of the following apply:
     o Care is primarily custodial in nature;
     o Beneficiary is not medically stable;
     o Services are provided by family or household members;
     o Treatment is provided as Long Term Services and Supports (LTSS), Home and Community Based Services (HCBS), or respite services;
     o Treatments are considered experimental or lack scientifically proven benefit; or
     o Services are provided by a Hawaii provider outside of the State.

2. Continued Service Criteria
   • see "Common Criteria and Best Practices for All Levels of Care":

3. Discharge Criteria
   • see "Common Criteria and Best Practices for All Levels of Care":

4. Clinical Best Practices
   • see "Common Criteria and Best Practices for All Levels of Care":
   • see also the Behavioral Clinical Policy, "Intensive Behavioral Therapy / Applied Behavior Analysis for Autism Spectrum Disorder":
   • A diagnostic evaluation is conducted by any of the following:
     o Developmental behavioral pediatrician
     o Developmental pediatrician
     o Neurologist
     o Pediatrician
     o Psychiatrist
     o Psychologist
The provider conducting the diagnostic evaluation refers a member who either meets the criteria for Autism Spectrum Disorder or who is provisionally diagnosed with Autism Spectrum Disorder for further assessment and treatment plan development.

Further assessment may be performed by the provider who conducted the diagnostic evaluation, or either of the following:

- Board-Certified Behavioral Doctorate (BCBA-D)
- Board-Certified Behavioral Analyst (BCBA)

A provider with expertise in Applied Behavior Analysis develops the treatment plan and provides treatment. In addition to the types of providers listed above, treating providers may be either of the following:

- Board-Certified Assistant Behavior Analyst (BCaBA)
- Registered Behavior Technician (RBT) performing under the supervision of a BCBA, BCaBA, or BCBA-D

The treatment plan:

- Addresses the identified behavioral, psychological, family and medical concerns;
- Has measurable goals in objective and measurable terms based on formalized assessments. The assessments address skill acquisition, the behaviors, and impairments for which the intervention is to be applied.
- Document that services will be delivered by a rendering provider who is licensed according to the requirements of the State of Hawaii’s Medicaid Program.

For each goal in the treatment plan, the provider documents a re-evaluation of progress toward treatment goals completed no later than 24 weeks after treatment began in order to establish a baseline in the areas of social skills, communication skills, language skills, behavior change, and adaptive functioning.

- The re-evaluation compares progress with the member’s baseline.
- The re-evaluation anticipates the timeline and treatment hours for achievement of each goal based on both the initial assessment and subsequent re-evaluations over the duration of treatment.

The provider affords documentation of progress toward treatment goals at least every 26 weeks including results from generally accepted measurement systems such as the Verbal Behavior Milestones Assessment (VB-MAPP) or Assessment of Basic Language and Learning Skills-Revised (ABLL-R®).

- When a member is undergoing a 26-week trial of Applied Behavior Analysis, documentation is afforded at least every 12 weeks.
- The treatment plan should be reviewed sooner when there has been a change in the member’s condition, or the member’s condition is not improving or it has worsened. When the member’s condition has not improved or it has worsened, the reassessment should determine whether the diagnosis is accurate, the treatment plan should be modified, or the member’s condition should be treated in another level of care.

REFERENCES*


*Additional reference materials can be found in the reference section(s) of the applicable Level of Care Guidelines and in the related Behavioral Clinical Policy.

HISTORY/REVISION INFORMATION

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<td>October, 2015</td>
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<tr>
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Per State of Hawaii Revised Statutes 432E-1.4, for contractual purposes, a health intervention shall be covered if it is an otherwise covered category of service, not specifically excluded, recommended by the treating licensed health care provider, and determined by the health plan's medical director to be medically necessary as defined in subsection (b). A health intervention may be medically indicated and not qualify as a covered benefit or meet the definition of medical necessity. A managed care plan may choose to cover health interventions that do not meet the definition of medical necessity.

A health intervention is medically necessary if it is recommended by the treating physician or treating licensed health care provider, is approved by the health plan's medical director or physician designee, and is:

1. For the purpose of treating a medical condition;
2. The most appropriate delivery or level of service, considering potential benefits and harms to the patient;
3. Known to be effective in improving health outcomes; provided that:
   A. Effectiveness is determined first by scientific evidence;
   B. If no scientific evidence exists, then by professional standards of care; and
   C. If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and
4. Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost-effective shall not necessarily mean the lowest price.

The treating licensed health care provider and the health plan's medical director or physician designee do not agree on whether a health intervention is medically necessary, a reviewing body, whether internal to the plan or external, shall give consideration to, but shall not be bound by, the recommendations of the treating licensed health care provider and the health plan's medical director or physician designee.

For the purposes of this section:

"Cost-effective" means a health intervention where the benefits and harms relative to the costs represent an economically efficient use of resources for patients with the medical condition being treated through the health intervention; provided that the characteristics of the individual patient shall be determinative when applying this criterion to an individual case.

"Effective" means a health intervention that may reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

A health intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied. New interventions for which clinical trials have not been conducted and effectiveness has not been scientifically established shall be evaluated on the basis of professional standards of care or expert opinion. For existing interventions, scientific evidence shall be considered first and, to the greatest extent possible, shall be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care shall be considered. If professional standards of care do not exist or are outdated or contradictory, decisions about existing interventions shall be based on expert opinion. Giving priority to scientific evidence shall not mean that coverage of existing interventions shall be denied in the absence of conclusive scientific evidence. Existing interventions may meet the definition of medical necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or in the absence of such standards, convincing expert opinion.

"Health outcomes" mean outcomes that affect health status as measured by the length or quality of a patient's life, primarily as perceived by the patient.

"Medical condition" means a disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation.

"Physician designee" means a physician or other health care practitioner designated to assist in the decision-making process who has training and credentials at least equal to the treating licensed health care provider.

"Scientific evidence" means controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and the health outcomes may be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases. Scientific evidence may be found in the following and similar sources:

1. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
2. Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medica (EMBASE), Medline, and MEDLARS database Health Services Technology Assessment Research (HSTAR);
3. Medical journals recognized by the Secretary of Health and Human Services under section 1861(t)(2) of the Social Security Act, as amended;
(5) Findings, studies, or research conducted by or under the auspices of federal agencies and nationally recognized federal research institutes including but not limited to the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and

(6) Peer-reviewed abstracts accepted for presentation at major medical association meetings.