



United Behavioral Health

Supplemental Clinical Criteria: Hawaii Medicaid Quest

Document Number: BH803HISCC122019

Effective Date: December 13, 2019

Table of Contents

- [Introduction and Instructions for Use](#)
- [Evidence-Based Practice Criteria](#)
- [Intensive Behavior Therapy/Applied Behavior Therapy](#)
- [References](#)
- [Revision History](#)

INTRODUCTION AND INSTRUCTIONS FOR USE

The following *State or Contract Specific Clinical Criteria*¹ defined by state regulations or contractual requirements are used to make medical necessity determinations, mandated for members of behavioral health plans managed by Optum and U.S. Behavioral Health Plan, California (doing business as OptumHealth Behavioral Solutions of California ("Optum-CA")).

Other *Clinical Criteria*² may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by Optum®³. These may be externally developed by independent third parties used in conjunction with or in place of these Clinical Criteria when required, or when state or contractual requirements are absent for certain covered services. 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 these Clinical Criteria. 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 Clinical Criteria and the member's specific benefit, the member's specific benefit supersedes these Clinical Criteria.

These Clinical Criteria are provided for informational purposes and do not constitute medical advice.

EVIDENCE-BASED PRACTICE CRITERIA

In addition to the applicable Clinical Criteria, for all services, treatments and levels of care, services are delivered according to evidence-based practices consistent with the applicable definition of Medical Necessity and the following:

- Services are:

¹ **Clinical Criteria (State or Contract Specific):** Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.

² **Clinical Criteria:** When state specific criteria are not available or do not apply, the following criteria are used:

(ASAM Criteria) Criteria used to make medical necessity determinations for substance-related disorder benefits.

(Level of Care Utilization System-LOCUS) Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make medical necessity determinations and placement decisions for adults ages 19 and older.

(Child and Adolescent Service Intensity Instrument-CASII)-Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make medical necessity determinations and to provide level of service intensity recommendations for children and adolescents ages 6-18.

(Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make medical necessity determinations and to provide level of service intensity recommendations for children ages 0-5.

³ Optum is a brand used by United Behavioral Health and its affiliates.

- Provided under an individualized plan of treatment or diagnostic plan developed in conjunction with providers of appropriate disciplines on the basis of a thorough evaluation of the member's strengths and disabilities;
- Supervised and evaluated by the most appropriate physician or provider;
- For the purpose of diagnosis or services are reasonably expected to improve the member's condition:
 - It is not necessary that a course of therapy have as its goal restoration of the member to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some members. For many other members, 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 services were withdrawn the member's condition would deteriorate, relapse further, or require hospitalization, this criterion is met.
- The individualized written plan includes the type, amount frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals.
- For continued service, the member continues to show improvement in accordance with his/her individualized treatment plan, and the frequency of services is within accepted norms of medical practice.
- Discharge is indicated when stability can be maintained without further treatment or with less intensive treatment.
 - Discharge planning includes linkages with community resources, supports, and providers in order to promote a member's return to a higher level of functioning in the least restrictive environment.
 - A discharge plan and a summary with recommendations for appropriate services concerning follow-up or aftercare have been developed as well as a summary of the member's condition upon discharge.

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.

The service is not Long-Term Services and Supports (LTSS), Home and Community Based Services (HCBS), or Respite Services.

Admission Criteria

- The member's current signs and symptoms meet criteria for Autism Spectrum Disorder, or Autism Spectrum Disorder is provisionally diagnosed.
 - 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 necessaryⁱ

AND

- Treatment is not covered when any of the following apply:
 - Care is primarily custodial in nature;
 - Beneficiary is not medically stable;
 - Services are provided by family or household members;
 - Treatment is provided as Long Term Services and Supports (LTSS), Home and Community Based Services (HCBS), or respite services;
 - Treatments are considered experimental or lack scientifically proven benefit; or
 - Services are provided by a Hawaii provider outside of the State.

Service Delivery

- A diagnostic evaluation is conducted by any of the following:
 - Developmental behavioral pediatrician
 - Developmental pediatrician
 - Neurologist
 - Pediatrician
 - Psychiatrist
 - Psychologist
 - Other license provider with expertise in Autism Spectrum Disorder
- 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®).

- o When a member is undergoing a 26-week trial of Applied Behavior Analysis, documentation is afforded at least every 12 weeks.
- o 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

State of Hawaii, Department of Human Services. (2015). Coverage of Intensive Behavioral Therapy (IBT) for Treatment of Children Under 21 Years of Age with Autism Spectrum Disorder (ASD).

State of Hawaii, Hawaii Revised Statutes. (2013). §432E-1.4, Medical Necessity.

REVISION HISTORY

Date	Action/Description
10/2015	• Version 1.
12/2016	• Version 2. Annual review.
01/2017	• Version 3. Annual review.
02/2018	• Version 4. Annual review.
12/2019	• Version 5. Annual review and revised per LOCUS/CASII/ECSII adoption.

¹ 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.

(b) 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.

(c) When 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.

(d) 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.

"Health intervention" means an item or service delivered or undertaken primarily to treat a medical condition or to maintain or restore functional ability. 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;
- (4) Standard reference compendia including the American Hospital Formulary Service-Drug Information, American Medical Association Drug Evaluation, American Dental Association Accepted Dental Therapeutics, and United States Pharmacopoeia-Drug Information;
- (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.