3704 POLICY

3704.1 APPLIED BEHAVIOR ANALYSIS POLICY

Medicaid will reimburse for ABA rendered to Medicaid eligible individuals of all ages, under age 21 years old in accordance with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage authority benefit plan. The EPSDT benefit plan encourages providers to follow the recommended schedule for screenings offered by the AAP for individuals under age 21. The behavior intervention must be medically necessary (reference MSM Chapter 100) to develop, maintain or restore to the maximum extent practical the functions of an individual with a diagnosis of ASD, FASD or other condition for which ABA is recognized as medically necessary. It must be rendered according to the written orders of the Physician, Physician's Assistant (NRS 630.271), Nevada Board of Psychological Examiners or an Advanced Practitioner Registered Nurse (APRN)/Nurse Practitioner (NP). The treatment regimen must be designed and signed off on by the qualified ABA provider.

The services are to be provided in the least restrictive, most normative setting possible and may be delivered in a medical professional clinic/office, within a community environment or in the recipient's home.

All services must be documented as medically necessary and appropriate and must be prescribed on an individualized treatment plan.

3704.2 COVERAGE AND LIMITATIONS

3704.2A COVERED SERVICES

1. There are two types of ABA treatment delivery models recognized by the DHCFP, Focused and Comprehensive. Based upon the Behavior Analyst Certification Board (BACB), Inc. (2014) within each of the two delivery models there are key characteristics which must be demonstrated throughout the assessment and treatment. These characteristics include:

    a. Comprehensive assessment that describes specific levels of baseline behaviors when establishing treatment goals.

    b. Establishing small units of behavior which builds towards larger changes in functioning in improved health and levels of independence.

    c. Understanding the current function and behaviors targeted for treatment.

    d. Use of individualized and detailed behavior analytic treatment.

e. Ongoing and frequent direct assessment, analysis and adjustments to the treatment plan by a Behavior Analyst by observations and objective data analysis.

f. Use of treatment protocols that are implemented repeatedly, frequently and consistently across all environments.

g. Direct support and training of family members and other involved qualified professionals.

h. Services directed to the individual recipient and related to health and welfare.

i. Supervision and management by a licensed provider with expertise and formal training in ABA for treatment of ASD. "Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers (2014) (2nd ed.)."

j. The maximum number of units that can be used for supervision is 20% of the total number of hours of direct therapy services provided, unless clinical documentation is submitted that supports a need for additional units.

k. Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and Safety Skills. These fundamental skills are crucial for individuals to maintain independence, enhance their quality of life, and ensure their safety in various environments.

a) **Activities of Daily Living (ADLs):** Activities of Daily Living (ADLs) refer to essential self-care tasks that individuals typically perform daily to maintain their personal well-being and independence. The ability to perform ADLs is crucial for individuals to live independently and maintain their dignity. These activities include, but are not limited to:

i) **Personal Hygiene:** Tasks such as bathing, grooming (including oral care and hair care), and maintaining continence.

ii) **Dressing:** Choosing appropriate clothing and putting it on, considering weather, occasion, and individual preferences.

iii) **Eating:** Independently feeding oneself, including preparation of food if applicable, and managing utensils.

iv) **Mobility:** Moving around safely within one's environment, which may include transferring from bed to chair, walking, or using mobility aids.

v) **Toileting:** Using the toilet or managing bowel and bladder function independently, including cleaning oneself afterwards.

b) **Instrumental Activities of Daily Living (IADLs):** Instrumental Activities of Daily Living (IADLs) are more complex tasks necessary for independent living within the community and significantly contribute to an individual's quality of life. Performance of tasks such as these requires mental/cognitive (memory, judgment, intellectual ability) and/or physical ability. IADLs include, but are not limited to:

i) **Household Management:** Managing tasks such as meal preparation, cleaning, and laundry.

ii) **Managing Finances:** Handling personal finances, budgeting, paying bills, financial exploitation/prevention, and managing financial transactions.

iii) **Shopping:** Planning and executing trips to purchase groceries, clothing, and other necessities.

iv) **Communication:** Using the telephone or other forms of communication effectively to maintain social connections and access services.

v) **Transportation:** Arranging and utilizing transportation to access community resources, medical appointments, and social activities.

c) **Safety Skills:** Safety skills encompass a defined set of behaviors crucial for ensuring physical and psychological well-being and minimizing the risk of harm in various environments. Cognitive vulnerabilities related to deficits in executive functioning, memory, and social communication skills are common. These social challenges are further complicated by impaired cause-and-effect reasoning leading to a lack of connection between behaviors and consequences, the inability to avoid risk, and self-protect from manipulation (e.g., bullying), often resulting in utilization of maladaptive expression of emotions (e.g., unhealthy perseveration, explosive rage, etc. These skills include, but are not limited to:

i) **Identifying and Avoiding Hazards:** Recognizing potential dangers like sharp objects, hot surfaces, or unsafe areas.

ii) **Following Safety Instructions:** Understanding and adhering to directives such as stopping at curbs, waiting for assistance, or using safety equipment.

iii) **Emergency Procedures:** Knowing how to respond effectively in emergencies such as fire drills, medical incidents, fire plan/prevention or getting lost.

iv) **Personal Boundaries:** Respecting personal space and understanding appropriate social behaviors to prevent conflicts, avoid manipulation, social vulnerabilities and maintain personal safety. This also includes developmentally appropriate understanding of consent/assent and consent/assent withdrawal.

v) **Traffic and Pedestrian Safety:** Learning safe navigation of streets, crosswalks, and parking lots to prevent accidents.

vi) **Water Safety:** Understanding the risks associated with bodies of water and learning basic water safety practices.

vii) **Medication Safety:** Recognizing medications, understanding dosage instructions, and safely accessing and using medications.

viii) **Online Safety:** Developing skills to navigate the internet safely, including recognizing and avoiding online dangers such as cyberbullying, scams, and inappropriate content.

d) Goals for ADLs, IADLs, and Safety Skills should meet the following criteria for expected outcomes:

i) **Functional:** Goals should focus on practical skills that directly contribute to the individual's ability to function independently in daily life.

ii) **Realistic:** Goals should be achievable within a reasonable timeframe based on the individual's abilities and circumstances. Reasonable timeframes will vary based on the individual, however, failure to achieve observable/measurable progress across 2 consecutive authorization periods, should result in modification or discontinuation of the goal.

iii) **Relevant:** Goals should be pertinent to the individual's current needs and priorities.

iv) **Transferable:** Skills acquired should be applicable and usable in the individual's current or anticipated environments.

v) **Evidence-based:** Goals should align with best practice standards and be supported by the professional community as safe and effective for the intended purpose.

2. Focused Delivery Model

a. Focused ABA is treatment directly provided to the individual for a limited number of specific behavior targets.

1. The appropriate target behaviors are prioritized. When prioritizing multiple target areas, the following behaviors are considered:

a. Behaviors that may threaten the health and safety of themselves or others; and

b. Absence of developmentally appropriate adaptive, social or functional skills.

2. Treatment may be delivered in individual or small group format.

3. Comprehensive Delivery Model

a. Comprehensive ABA is treatment provided to the individual for a multiple number of targets across domains of functioning including cognitive, communicative, social, and emotional.

1. The behavior disorders may include co-occurring disorders such as aggression, self-injury, and other dangerous disorders.

2. Treatment hours are increased and decreased as recipient responds to treatment goals.

3. Treatment is intensive and initially provided in a structured therapy setting. As the recipient progresses towards treatment goals the setting may be expanded to alternative environments such as group settings.

4. Daily and Weekly Limits

a. Providers are limited to 12 hours of ABA services per day.

b. Recipients are limited to 40 hours of ABA services per week.

5. Services covered within the ABA delivery models

a. Behavior Screening – A brief systematic process to determine developmental delays and disabilities during regular well-child doctor visits. Screens must be a nationally accepted Developmental Screen. A recommended list of screens may be found at: https://www.cdc.gov/ncbddd/autism/hcp-screening.html.

Refer to MSM Chapter 600 for coverage of developmental screens.

b. Comprehensive Evaluations – Is the further review and diagnosis of the child's behavior and development. Coverage of this service is found within MSM Chapter 600.

c. Behavior Assessment – A comprehensive assessment is an individualized examination which establishes the presence or absence of developmental delays and/or disabilities and determines the recipient's readiness for change and identifies the strengths or problem areas that may affect the recipient's treatment. The comprehensive assessment process includes an extensive recipient history which may include: current medical conditions, past medical history, labs and diagnostics, medication history, substance abuse history, legal history, family, educational and social history, and risk assessment. The information collected from this comprehensive assessment shall be used to determine appropriate interventions and treatment planning.

d. Adaptive Behavior Treatment Intervention – Is the systematic use of behavior techniques and intervention procedures to include intensive direction instruction by the interventionist and family training and support.

e. Adaptive Behavior Family Treatment – The training in behavior techniques to be incorporated into daily routines of the child and ensure consistency in the intervention approach. The training should be extensive and ongoing and include regular consultation with the qualified professional. The training is broken down into two components:

1. Family Treatment with the child present – Is training that includes the parent/guardian or authorized representative in behavior techniques during the behavior intervention with the child.

2. Family Treatment without the child present – Is training in behavior techniques provided to the parent/guardian or authorized representative without the child present. The training may be for the review of prior adaptive behavior treatment sessions to break down the exhibited behavior and training techniques.

f. Tests acceptable as diagnostic tools for ASD include:

1. Autism Diagnostic Observation Schedule, 2nd Ed. (ADOS-2)

2. Childhood Autism Rating Scale, 2nd Ed. (CARS-2)

3. Gilliam Autism Rating Scale, 3rd Ed. (GARS-3)

4. Fetal Alcohol Spectrum Disorders (FASD) Diagnostic Category.

g. If Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5) criteria alone are used as the sole basis for diagnosis the provider must submit documentation of the specific DSM-5 criteria that were met.

6. The coverage of ABA services requires the following medical coverage criteria to be met:

a. The recipient must be Medicaid Eligible;

b. Have an established supporting diagnosis of ASD, FASD, or other condition for which ABA is recognized as medically necessary. The diagnosis is to be completed only one time. Repeat testing should not be performed when full criteria were previously met. Diagnosis is to be documented on the FA-11F.

Tests acceptable as diagnostic tools for ASD include:

1. Autism Diagnostic Observation Schedule, 2nd Ed. (ADOS-2)

2. Childhood Autism Rating Scale, 2nd Ed. (CARS-2)

3. Gilliam Autism Rating Scale, 3rd Ed. (GARS-3)

4. Fetal Alcohol Spectrum Disorders (FASD) Diagnostic Category.

If Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5) criteria alone are used as the sole basis for diagnosis the provider must submit documentation of the specific DSM-5 criteria that were met.

c. The individual exhibits excesses and/or deficits of behavior that impedes access to age-appropriate home or community activities (examples include, but are not limited to aggression, self-injury, elopement, and/or social interaction, independent living, play and/or communication skills, etc.);

d. ABA services are rendered in accordance with the individual's treatment plan with realistic, functional and obtainable treatment goals to address the behavior dysfunction;

e. The individual exhibits cognitive impairments in learning, memory, executive functioning, adaptive functioning, self-regulation that contribute to deficits in cause-and-effect thinking that increases the chance of exploitation, manipulation, and/or social isolation.

f. Treatment may vary in intensity and duration based on clinical standards. Approval of fewer hours than recommended/supported in clinical literature requires justification based on objective findings in the medical records;

g. A reasonable expectation on the part of the treating healthcare professional that the individual will improve, or maintain to the maximum extent practical functional gains with behavior intervention services;

h. The treatment plan must be based on evidence-based assessment criteria and the individual's test results; and

i. Services must be prior authorized.

7. Services may be delivered in an individual or group (two to eight individuals) treatment session.

8. Services may be delivered in the natural setting (i.e. home, school and community-based settings, including clinics).

9. Individuals with Disabilities Education Act (IDEA) related services:

a. Part C, Early Intervention ages zero up to three years old – Services identified on an Individualized Family Services Plan (IFSP) may be billed to the DHCFP when the providers are enrolled and meet the provider qualifications as outlined under "provider qualifications" for ABA service. These providers must directly bill the DHCFP.

b. Part B, Special Education and related services ages three up to 21 years old – Services identified on an Individualized Educational Program (IEP) may be billed to the DHCFP when the providers are enrolled and meet the provider qualifications as outlined under "provider qualifications" for ABA services. These providers must directly bill DHCFP.

c. School Health Services Medicaid Services Manual 2800 is to be referenced for these services.