# AETNA BETTER HEALTH®

d/b/a Aetna Better Health of Louisiana

## Policy

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| Policy Name: | Applied Behavior Analysis | Page: | 1 of 11 |
| Department: | Medical Management | Policy Number: | 7000.11 |
| Subsection: | Prior Authorization | Effective Date: | 01/20/2022 |
| Applies to: | ■ Medicaid Health Plans | | |

***PURPOSE:***

The purpose of this policy is to define Aetna Better Health's business standards for the prior authorization of Applied Behavior Analysis (ABA).

***STATEMENT OF OBJECTIVE:***

Objectives of the ABA prior authorization process are to:

- Accurately document all ABA authorization requests
- Verify that a member is eligible to receive ABA at the time of the request and on each date of service
- Assist providers in providing appropriate, timely, and cost-effective ABA
- Verify the practitioner's or provider's network participation
- Define responsibilities of health professionals involved in the medical necessity decision making process
- Evaluate and determine medical necessity and/or need for additional supporting documentation
- Collaborate and communicate as appropriate for the coordination of members' care
- Facilitate timely claims payment by issuing prior authorization numbers to practitioners or providers for submission with claims for approved services
- Establish protocol for working with out-of-network ABA providers to facilitate SCA's as needed to secure appropriate treatment for members

***DEFINITIONS:***

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| MCG® | MCG, including Chronic Care Guidelines, are evidence-based clinical guidelines that are updated annually. They support prospective, concurrent, and retrospective reviews; proactive care management; discharge planning; patient education, and quality initiatives. |

***LEGAL/CONTRACT REFERENCE:***

The ABA prior authorization process is governed by:

- 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 8.0

- Applicable federal and state laws, regulations and directives, including the confidentiality of member information (e.g., Health Insurance Portability and Accountability Act [HIPAA])
- National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans 2021
- Policy 7000.30 Process for Approving and Applying Medical Necessity Criteria
- Louisiana Department of Health (LDH) ABA Provider Manual

***FOCUS/DISPOSITION:***

ABA therapy is the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including direct observation, measurement, and functional analysis of the relations between environment and behavior. ABA-based therapies teach skills through the use of behavioral observation and reinforcement or prompting to teach each step of targeted behavior. ABA is a covered service for members under the age of 21 who:

• Exhibit the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities (e.g., aggression, self-injury, elopement, etc.);
• Have been diagnosed with a condition for which ABA-based therapy services are recognized as therapeutically appropriate, including autism spectrum disorder, by a qualified health care professional;
• Had a comprehensive diagnostic evaluation by a qualified health care professional; and
• Have a prescription for ABA-based therapy services ordered by a qualified health care professional.[1]

***Aetna Better Health Responsibilities***

The chief medical officer (CMO) is responsible for directing and overseeing the Aetna Better Health prior authorization of ABA. The Prior Authorization department is principally responsible for carrying out the day-to-day operations (e.g., evaluating requests, documenting requests and decisions, and issuing authorization numbers for approved requests) under the supervision of a medical director or designated licensed clinical professional qualified by

[1] LDH Applied Behavior Analysis Provider Manual, Section 4.0, page 1; Section 4.1, page 1; and Section 4.2, page 1

training, experience and certification/licensure to conduct the utilization management (UM) functions in accordance with state and federal regulations.[2] Other departments approved by the CMO (such as Care Management and Concurrent Review) may issue authorizations for specific services within their areas of responsibility per contractual requirements. Departments with authority to authorize services will maintain a postal address, direct telephone, fax number, or electronic interchange (if available) for receiving and responding to notifications and service authorization requests. Only a health care professional may make determinations regarding the medical necessity of health care services during the course of utilization review.

When initiating or returning calls regarding UM issues, Aetna Better Health requires UM staff to identify themselves by name, title, and organization name;[3] and upon request, verbally inform member, facility personnel, the attending physician and other ordering practitioners/providers of specific UM requirements and procedures. Aetna Better Health must triage incoming standard and expedited requests for services based upon the need for urgency due to the member's health condition. Aetna Better Health must identify the qualification of staff who will determine medical necessity.[4]

Nonclinical staff is responsible for:[5]

- Documenting incoming prior authorization requests and screening for member's enrollment, member eligibility, and practitioner/provider affiliation
- Forwarding to clinical reviewers any requests that require a medical necessity review

Clinical reviewer's responsibilities include:[6]

- Identifying service requests that may potentially be denied or reduced on the basis of medical necessity
- Forwarding potential denials or reductions to the CMO or designated medical director for review
- If services are to be denied or reduced:
  - Providing written notification of denials/reductions to members

[2] NCQA HP 2021 UM4 A1
[3] NCQA HP 2021 UM3 A3
[4] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 8.1.13
[5] NCQA HP 2021 UM4 A2
[6] NCQA HP 2021 UM4 A1-2

- Notifying the requesting practitioner/provider and member of the decision to deny, reduce or terminate reimbursement within the applicable time frame
- Documenting, or informing data entry staff to document the denial decision in the business application system prior authorization module

***Medical Director Reviewer Responsibilities***

Authorization requests that do not meet criteria for ABA will be presented to the behavioral health medical director for review. The behavioral health medical director conducting the review will have clinical expertise in treating the member's condition or disease and be qualified by training, experience and certification/licensure to conduct the prior authorization functions in accordance with state and federal regulations. The behavioral health medical director will review the ABA request, the member's need, and the clinical information presented. Using the approved criteria and the behavioral health medical director's clinical judgment, a determination is made to approve, deny or reduce the service. Only the behavioral health medical director can reduce or deny a request for ABA based on a medical necessity review.[7]

Practitioners/providers are notified in the denial letter (i.e., Notice of Action [NOA]) that they may request a peer-to-peer consultation to discuss denied or reduced service authorizations with the behavioral health medical director reviewer by calling Aetna Better Health. All behavioral health medical director discussions and actions, including discussions between medical directors and treating practitioners/providers are to be documented in the Aetna Better Health authorization system.[8]

As part of Aetna Better Health's appeal procedures, Aetna Better Health will include an Informal Reconsideration process that allows the member (or provider/agent on behalf of a member with the member's written consent) a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.[9]

[7] NCQA HP 2021 UM4 F1
[8] NCQA HP 2021 UM7 D
[9] 2020 Louisiana Medicaid Managed Care Organization Statement of Work, Section 8.5.4.1.3.1 and 8.5.4.1.3.2

***Prior Authorization of ABA***

ABA requires prior authorization. Prior to requesting ABA services, the member must have documentation indicating medical necessity for the services through a completed comprehensive diagnostic evaluation (CDE) that has been performed by a qualified health care professional (QHCP). A QHCP is defined as a:

- Pediatric Neurologist;
- Developmental Pediatrician;
- Psychologist (including a Medical Psychologist);
- Psychiatrist (particularly Pediatric and Child Psychiatrist); or
- Licensed individual that has been approved by the Aetna Better Health medical director as meeting the requirements of a QHCP when:
    - The individual's scope of practice includes differential diagnosis of Autism Spectrum Disorder and comorbid disorders for the age and/or cognitive level of the beneficiary; and
    - The individual has at least two years of experience providing such diagnostic assessments and treatments.

The CDE must include at a minimum:

- A thorough clinical history with the informed parent/caregiver, inclusive of developmental and psychosocial history;
- Direct observation of the beneficiary, to include but not be limited to, assessment of current functioning in the areas of social and communicative behaviors and play or peer interactive behaviors;
- A review of available records;
- A valid Diagnostic and Statistical Manual of Mental Disorders, (DSM) V (or current edition) diagnosis;
- Justification/rationale for referral/non-referral for an ABA functional assessment and possible ABA services; and
- Recommendations for any additional treatment, care or services, specialty medical or behavioral referrals, specialty consultations, and/or any additional recommended

standardized measures, labs or other diagnostic evaluations considered clinically appropriate and/or medically necessary.[10]

The licensed professional supervising treatment is required to perform a functional assessment of the beneficiary utilizing the outcomes from the CDE, and develop a behavior treatment plan. Services for "Behavior Identification Assessment" must be prior authorized by Aetna Better Health. Once services commence, additional assessments at a minimum shall occur every six months. The authorization period for such assessments shall not exceed 180 days. In exceptional circumstances, at the discretion of Aetna Better Health, an additional assessment may be authorized. The behavior identification supporting assessment must be prior authorized. Supporting assessments may be approved to allow technicians to gather information that support the licensed professional completing the assessment. The authorization period for such assessments shall not exceed 180 days. Behavior identification supporting assessment conducted with two or more technicians, must be prior authorized and treated in the same manner as the behavior identification supporting assessment above. However, such assessment may be administered by the physician or other QHCP who is on-site but not necessarily face-to-face; with the assistance of two or more technicians. This is only medically necessary when the beneficiary's behavior is so destructive that it requires the presence of a team and an environment customizable to the beneficiary's behavior. All three assessment services can occur on the same day and continue as prior authorized until the assessment is completed.[11]

The behavior treatment plan identifies the treatment goals along with providing instructions to increase or decrease the targeted behaviors. The behavior treatment plan must:

- Be person-centered and based upon individualized goals;
- Delineate the frequency of baseline behaviors and the treatment development plan to address the behaviors;
- Identify long-term, intermediate, and short-term goals and objectives that are behaviorally defined;
- Identify the criteria that will be used to measure achievement of behavior objectives;
- Clearly identify the schedule of services planned and the individual providers responsible for delivering the services;

[10] LDH Applied Behavior Analysis Provider Manual, Section 4.1, page 1-2
[11] LDH Applied Behavior Analysis Provider Manual, Section 4.1, page 3

- Include care coordination, involving the parent(s) or caregiver(s), school, state disability programs, and others as applicable;
- Include parent/caregiver training, support, education, and participation;
- Identify objectives that are specific, measurable, based upon clinical observations of the outcome measurement assessment, and tailored to the beneficiary; and
- Ensure that interventions are consistent with ABA techniques.[12]

The provider may use the LDH treatment plan template or their own form. If the provider chooses to use their own form, the provider must address ALL of the relevant information specified in the LDH treatment plan template. The behavior treatment plan must indicate that direct observation occurred and describe what happened during the direct observation. If there are behaviors being reported that did not occur and these behaviors are being addressed in the behavior treatment plan, indicate all situations and frequencies at which these behaviors have occurred and have been documented. If there is documentation from another source, that documentation must be attached. If there is any other evidence of the behaviors observed during the direct observation and that are proof of these behaviors, these must be reported on the behavior treatment plan as well. The behavior treatment plan shall include a weekly schedule detailing the number of expected hours per week and the location for the requested ABA services. In addition, the provider shall indicate both the intensity and frequency of the therapy being requested and the justification for this level of service. When developing a treatment plan, it is necessary to request only services that are medically necessary as determined through the assessment. Any model of ABA services can be approved if it achieves the goals set forth in the assessment. All services do not need to be part of the treatment plan, or used in conjunction with each other, unless technician services are being provided. If technician services are being provided, supervision by a licensed behavior analyst must be a part of the treatment plan.[13]

***Medical Necessity Criteria***

In addition to the LDH ABA Provider Manual, the primary medical necessity criteria used to authorize ABA services is 25th Edition MCG Applied Behavioral Analysis ORG: B-806-T

[12] LDH Applied Behavior Analysis Provider Manual, Section 4.1, page 3-4
[13] LDH Applied Behavior Analysis Provider Manual, Section 4.1, page 4-5

(BHG). In instances where the criteria differ, Aetna Better Health follows the LDH ABA Provider Manual guidelines.

Aetna Better Health requires that all of the following is present:

- Moderate Psychiatric, behavioral, or other comorbid conditions.
- Serious dysfunction in daily living.
- Situation and expectations are appropriate for ABA as indicated by all of the following:
    - Recommended treatment is necessary and not appropriate for less intensive care (ie, patient behavior, symptoms, or risk is inappropriate for routine outpatient office care).
    - Patient is assessed as not at risk of imminent danger to self or others.
    - Treatment is to be administered in setting (eg, home vs specialized center) and by team (eg, multidisciplinary) that is specifically designed and compatible with patient's needs and abilities.
    - Targeted symptoms, behaviors, and functional impairments related to underlying behavioral health disorder have been identified as appropriate for ABA.
    - Treatment plan addresses comorbid medical, psychiatric, and substance use disorders, and includes coordination of care with other providers and community-based resources, as appropriate.
    - Treatment plan includes explicit and measurable recovery goals that will define patient improvement, with regular assessment that progress toward goals is occurring or that condition would deteriorate in absence of continued ABA.
    - Treatment plan engages family, caregivers, and other people impacted by and in position to affect patient behavior, as appropriate.
    - Treatment intensity (ie, number of hours per week) and duration (ie, length of service intervention) is individualized and designed to meet needs of patient and adjusted as is clinically appropriate.
    - Patient is expected to be able to adequately participate in and respond as planned to proposed treatment.[14]

[14] 25th Edition MCG Applied Behavioral Analysis ORG: B-806-T (BHG)

***OPERATING PROTOCOL:***

***Systems***

The business application system has the capacity to electronically store and report all service authorization requests, decisions made by Aetna Better Health regarding the service requests, clinical data to support the decision, and timeframes for notification to practitioners/providers and members of decisions.

Prior authorization requests, decisions and status are documented in the business application system prior authorization module.

***Measurement***

The Prior Authorization department measures:

- Volume of requests received by telephone, facsimile, mail, and website, respectively
- Service level
- Timeliness of decisions and notifications
- Process performance rates for the following, using established standards:
  - Telephone abandonment rate: under five percent (5%)
  - Average telephone answer time: within thirty (30) seconds
  - Consistency in the use of criteria in the decision-making process among Prior Authorization staff measured by annual inter-rater reliability audits
  - Consistency in documentation by department file audits at least quarterly
- Percentage of prior authorization requests approved
- Trend analysis of prior authorization requests approved
- Percentage of prior authorization requests denied
- Trend analysis of prior authorization requests denied

***Reporting***

- Monthly report to the CMO of the following:
  - Number of incoming calls
  - Call abandonment rate

  - Trend analysis of incoming calls
  - Average telephone answer time
  - Total authorization requests by source – mail, fax, phone, web
  - Number of denials by type (administrative/medical necessity)
- Utilization tracking and trending is reviewed by the CMO on a monthly basis and is reported at a minimum of quarterly to the QM/UM Committee
- Annual report of inter-rater reliability assessment results

***INTER-/INTRA-DEPENDENCIES:***

***Internal***

- Claims
- Chief medical officer/medical directors
- Finance
- Information Technology
- Medical Management
- Member Services
- Provider Services
- Quality Management
- Quality Management/Utilization Management Committee

***External***

- Members
- Practitioners and providers
- Regulatory bodies

Aetna Better Health

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