



Origination: 03/2017
Last Approved: 03/2017
Last Revised: 03/2017
Next Review: 03/2018
Owner: Carmen McIntyre: Chief Medical Officer
Policy Area: Clinical Practice Improvement
References:

Clinical Practice Guidelines

POLICY

It is the policy of the Detroit Wayne Mental Health Authority (DWMHA) that our service providers utilize established practices, as approved by the Michigan Department of Health and Human Services (DHHS), or as endorsed or mandated by DWMHA. DWMHA establishes preferred practices based on the state of the literature in related fields; collaboration with our academic partners; research conducted within our system; practices endorsed by DHHS; and practices listed by the Substance Abuse and Mental Health Services Administration (SAMHSA).

PURPOSE

The purpose of this policy is to ensure that enrollees/members treated under the auspices of DWMHA receive effective treatment. This treatment should be evidence-based, and/or accepted best practices, and/or mandated/endorsed by MDHHS and DWMHA.

APPLICATION

All DWMHA direct and subcontracted clinical service providers, or managers of clinical service providers, for all specialty behavioral health contracts are required to implement and monitor policies consistent with this guideline.

KEY WORDS

1. Evidence- Based Practice
2. Best Practice
3. Emerging Practice

STANDARDS

1. MDHHS sets the primary practices supported for the delivery of clinical services in its specialty behavioral health and substance abuse services system, otherwise known as the Public Mental Health System. The current iteration of its Practices Improvement Steering Committee lay out the System of Care based on Recovery for adults with mental illness (AMI); System of Care for children with serious emotional disturbance and their families (SED); and Improved Practices for people with Intellectual and/or Developmental Disabilities (IDD).

2. The AMI practice guidelines include the following practices: recovery; certified peer support specialists; advanced directives for mental health care; integrated treatment for enrollees/members with mental health and substance use disorders; family psycho-education; assertive community treatment; motivational interviewing train the trainer model; evidence-based supported employment; jail diversion; dialectical behavior therapy; initiatives of enrollees/members with dementia and their caregivers; cognitive behavioral therapy; supported employment; supported education; supported housing; and trauma-informed care.
3. DWMHA has additionally set guidelines for Case Management/Care Coordination; Management of Depression in Adults; and Screening for Diabetes in enrollees/members with Schizophrenia and Bipolar Disorder on Antipsychotic Medications, Autism Spectrum Disorder Applied Behavioral Analysis and Complex Case Management based on analysis of HEDIS data, practitioner discussions and quality improvement activities.
4. The SED practice guidelines include the following: parent management training-Oregon Model (PMTO); multisystemic therapy; trauma-informed care; wraparound; infant mental health; integrated care; juvenile justice diversion; parent support partners and youth peer support.
5. DWMHA further supports: Fatherhood Initiative; Youth United; Youth MOVE Michigan; Kids-TALK; Integrated Care; and the Cornerstone Replication Project. DWMHA further supports services to special populations including LGBTQ2S, Child Welfare, Juvenile Justice, and Zero to Three.
6. The IDD practice guidelines include peer mentors; self-determination; community inclusion and integrated care.
7. Cultural Competency is required across all levels.
8. Substance Abuse practice guidelines are addressed separately.
9. Communication of the guidelines: MDHHS standards are regularly updated on the michigan.gov website via the Improving Practices reports. Each subspecialty (AMI, SED, IDD, SUD) have MDHHS-level practice improvement committees which routinely report meeting minutes and updates.
 - a. These state-level communications are relayed to provider-DWMHA staff through the DWMHA population-specific committees: AMI learning collaborative; SED Connections; IDD learning collaborative; and SUD provider meetings.
 1. These practice improvement work groups are responsible for establishing the mechanisms by which any state-level changes will be implemented and proposes new, local-level initiatives.
 - b. Furthermore, a similar cascade shall communicate and implement physician clinical practices: State Level Behavioral Health Medicaid Director's Meeting to the Tri-County (Wayne, Macomb, and Oakland Counties) Medical Directors Meeting, to the system's provider network via emailed meeting minutes as well as website-posted folders.
10. The DWMHA-level work groups report to the DWMHA Improving Practices Leadership Team (IPLT), which includes enrollees from Quality Management, Utilization Management, and the Office of Peer/ Participant Advocacy (OPA). IPLT assists in determining priorities and providing Practice Improvement initiatives to the Quality Improvement Steering Committee (QISC) for inclusion in the Quality Assurance Performance Improvement Plan (QAPIP).
11. Further communication of the practice guidelines occurs through posting of the practice guidelines on the DWMHA website via the policy manual; communication in the DWMHA Partnership meetings with providers and Managers of Comprehensive Provider Networks (MCPN); the population-specific practice improvement workgroups via the Provider and MCPN membership; delivers training on new or refresher

guidelines directly as well as through our electronic learning platform, the Virtual Center for Excellence (VCE). VCE training notices are emailed to the contracted provider community. Minutes of the AMI learning collaborative are posted online.

12. The Clinical Practice Guidelines are reviewed and updated at least every two (2) years or more frequently if national guidelines change during that two (2) year period.
13. DWMHA monitors providers compliance with clinical guidelines through reports, treatment chart reviews, and/or process indicators.

QUALITY ASSURANCE/IMPROVEMENT

DWMHA shall review and monitor contractor adherence to this policy as one element in its Network Management Program, and as one element of the QAPIP Goals and Objectives.

The Quality Improvement Programs of MCPNs, their subcontractors, and direct contractors must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy.

COMPLIANCE WITH ALL APPLICABLE LAWS

DWMHA staff, MCPNs, contractors and subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

LEGAL AUTHORITY

RELATED POLICIES

1. Case Management (including Assertive Community Treatment)
2. Management of Adult Major Depression
3. Complex Care Management
4. Referral, Coordination and Integration of Care

RELATED DEPARTMENTS

1. Clinical Practice Improvement
2. Integrated Health Care
3. Quality Improvement
4. Utilization Management
5. Substance Use Disorders

CLINICAL POLICY

YES

INTERNAL/EXTERNAL POLICY

EXTERNAL

EXHIBIT(S)

1. DWMHA ASD Clinical Practice Standards 9.20.16
2. Management of Adults with Depression
3. Measurement of the PHQ9
4. Screening of diabetes in schizophrenic and bipolar enrollee/members on antipsychotics

Attachments:

[DWMHA ASD Clinical Practice Standards 9.20.16.docx](#)
[Management of Adults with Depression.docx](#)
[Measurement of the PHQ9.docx](#)
[SCREENING MEMBERS WITH SCHIZOPHRENIA AND BIPOLAR DISORDER ON ANTI2 \(2\) \(2\).docx](#)
[tool_phq9 \(1\).pdf](#)

Approval Signatures

Approver	Date
Ronald Hocking: Chief Operating Officer	03/2017
Dana Lasenby: Deputy Chief Operating Officer	03/2017
Allison Smith: Project Manager, PMP	03/2017
Bessie Tetteh: CIO	03/2017
Darlene Owens: Director, Substance Use Disorders, Initiatives	03/2017
Jody Connally: Director, Human Resources	03/2017
tracey Lee: Director Claims Management	03/2017
Kip Kliber: Director, Recipient Rights	03/2017
Muddasar Tawakkul: Director of Compliance/Purchasing [AS]	03/2017
Stacie Durant: CFO Management & Budget [AS]	03/2017
Julia Kyle: Director of Integrated Care	03/2017
Maha Sulaiman	03/2017
Mary Allix	03/2017
Crystal Palmer: Director, Children's Initiatives	03/2017
Rolf Lowe: Assistant General Counsel/HIPAA Privacy Officer	03/2017
Michele Vasconcellos: Director, Customer Service	03/2017
Corine Mann: Chief Strategic Officer/Quality Improvement	03/2017

Approver	Date
Sarah Sharp: Consultant	03/2017
Diana Hallifield: Consultant	02/2017
Carmen McIntyre: Chief Medical Officer	02/2017

COPY

Clinical Practice Standards Manual

EVIDENCE-BASED APPLIED BEHAVIOR ANALYSIS BENEFIT

Comprehensive Diagnostic Evaluation,
Cognitive Testing & Adaptive Testing,
Applied Behavior Analysis Assessments,
Behavior Technician Direction & Observation,
Applied Behavior Analysis Direct Service Delivery,
and
Applied Behavior Analysis Parent/Guardian Training



Table of Contents:

	Topic	Page Number
I.	<i>Introduction</i>	3
II.	<i>Autism Spectrum Disorder Overview</i>	3-4
III.	<i>Medicaid Autism Benefit Eligibility and Discharge Criteria</i>	4-6
IV.A.	<i>Services: Screening & Referral</i>	6-7
IV.B.	<i>Services: Comprehensive Diagnosis & Re-evaluation</i>	7-9
IV.C.	<i>Services: Behavior Assessment & Plan of Care</i>	9-13
IV. D.	<i>Services: Functional Behavioral Assessment</i>	13
IV.E.	<i>Services: Applied Behavior Analysis Direct Service & Treatment Packages</i>	13-19
IV.F.	<i>Services: Behavior Technician Direction & Observation</i>	19-20
IV.G.	<i>Services: Parent and Caregiver Training</i>	20
V.	<i>Service Authorization Chart</i>	21
VI.	<i>Staffing</i>	21-23
VII.	<i>Staffing Compliance Chart</i>	23-27
VIII.	<i>References</i>	27-28

I. Introduction:

The purpose of this document is to guide clinical decision-making and care for the Detroit Wayne Mental Health Authority Network for the delivery of the Medicaid Autism Spectrum Disorder (ASD) Applied Behavior Analysis (ABA) Benefit for individual's ages 0-21. It is important to note that these guidelines are limited to only the specific services available to individuals enrolled in the Medicaid ASD Benefit. It is also important to note that individuals with Autism either enrolled or not enrolled in the Medicaid ASD Benefit have access to a number of additional services that are not noted in this document and can be identified in the *Michigan Medicaid Provider Manual*. Finally, these guidelines are not aimed to take away from individualized person-centered treatment as each individual with ASD is unique.

The U.S. Centers for Disease Control and Prevention identified the Autism Spectrum Disorder (ASD) national prevalence rate to one in 68 children (1 in 42 boys and 1 in 189 girls). ASD occurs in all racial, ethnic and socioeconomic groups. As the fastest growing serious developmental disability in the United States, it costs the nation \$137 billion per year, a figure expected to increase over the next decade. Lifetime costs for a person on the spectrum are estimated to be \$3.2 million over the person's life, including costs for education, home and community-based services, and lost individual and family income.

To help children with ASD, it is essential to focus on the earliest years of development, since this is a critically important time for early learning which powerfully affects the child's future life course. Research shows that early diagnosis and intensive early intervention can produce the best outcomes and greatly improve the child's functioning. Without proper diagnosis and early intervention, individuals with ASD may require increased supportive services than an individual with ASD who did receive early intervention services.

Ganz (2007) indicates that most of the lifetime costs for an individual with ASD are incurred after the age of 21. Intensive early intervention has the potential to reduce long-range costs therefore we need to prioritize intensive intervention in early childhood and allocate the necessary resources for implementation of effective interventions. Not only is this in keeping with what we know to be best practice, there is considerable evidence that early intervention is cost-effective as it reduces financial costs while improving the quality of life for individuals and their family.

II. Autism Spectrum Disorders (ASD):

Autism Spectrum Disorders (ASD) are complex neurobiological disorders that present varying degrees of impairment in communication skills, social interactions, and restricted, repetitive, and stereotyped patterns of behavior, among other behavioral and physiological symptoms (CDC, 2011). The "autism spectrum" refers to the continuum of symptom severity and expression that individuals with ASD can experience. How ASD is manifested and how severely it affects one's life is distinct for each individual. As the word "spectrum" implies, individuals diagnosed with ASD are each unique. They may be extremely verbal or entirely nonverbal. Although everyone with an ASD has challenges in certain areas, some might be gifted in other areas. Although the exact cause of ASD remains unknown, research is revealing there may be multiple factors that contribute to the disorder, which would explain its variability.

At present, there is no medical test and no cure for ASD, and many individuals with ASD will need lifelong supports and services. Having an ASD significantly impacts a person's ability to function in his or her home, school, and community due to challenges in communication, learning, and forming relationships. Many individuals with ASD have other disabilities, such as intellectual impairment or emotional or behavioral

Medicaid Autism Spectrum Disorder Benefit Services

Revised: September 20, 2016; DWMHA Approved: February 21, 2017

disorders, which impair their overall level of functioning. Additionally, those with ASD frequently experience other chronic medical conditions, including immune system and gastrointestinal disorders, seizure disorders, and/or psychiatric conditions such as anxiety and depression. Any single individual with ASD will have a unique mix of symptoms within a complex array of ASD and coexisting conditions, which may change over time. Although there is no cure, educational programs and specialized interventions can lead to meaningful improvements for individuals with ASD (National Research Council Report, 2001).

III. Medicaid Autism Benefit Eligibility and Discharge Criteria:

A. **Medical Necessity:** Medical necessity and recommendation for ABA services is determined by a physician, or other licensed practitioner working within their scope of practice under state law. The child must demonstrate substantial functional impairment in social communication, patterns of behavior, and social interaction as evidenced by meeting criteria 1 and 2 listed below; and require ABA services to address identified impairments:

1. The child currently demonstrates substantial functional impairment in social communication and social interaction across multiple contexts, and is manifested by **all of the following**:
 - i. Deficits in social-emotional reciprocity ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation, to reduced sharing of interests, emotions, or affect, to failure to initiate or respond to social interactions.
 - ii. Deficits in nonverbal communicative behaviors used for social interaction ranging, for example, from poorly integrated verbal and nonverbal communication, to abnormalities in eye contact and body language or deficits in understanding and use of gestures, to a total lack of facial expressions and nonverbal communication.
 - iii. Deficits in developing, maintaining, and understanding relationships ranging, for example, from difficulties adjusting behavior to suit various social contexts, to difficulties in sharing imaginative play or in making friends, to absence of interest in peers.
2. The child currently demonstrates substantial restricted, repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by **at least two of the following**:
 - i. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, and/or idiosyncratic phrases).
 - ii. Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, and/or need to take same route or eat the same food every day).
 - iii. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, and/or excessively circumscribed or perseverative interest).
 - iv. Hyper- or hypo- reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific

Clinical Practice Standards Manual

Medicaid Autism Spectrum Disorder Benefit Services

Revised: September 20, 2016; DWMHA Approved: February 21, 2017

sounds or textures, excessive smelling or touching of objects, and/or visual fascination with lights or movement).

- A. Eligibility Criteria:** The following is the process for determining eligibility for ABA services for a child with a confirmed diagnosis of ASD. Eligibility determination and recommendation for ABA must be performed by a qualified licensed practitioner.
1. Consumer is under 21 years of age.
 2. Consumer resides in Wayne County or has Wayne County as identified County of Financial Responsibility (COFR).
 3. Consumer has active Medicaid.
 4. Consumer received a diagnosis of ASD from a qualified licensed practitioner utilizing valid evaluation tools.
 5. Consumer is medically able to benefit from the ABA treatment.
 6. Treatment outcomes are expected to result in a generalization of adaptive behaviors across different settings to maintain the ABA interventions and that they can be demonstrated beyond the treatment sessions. Measurable variables may include increased social-communication, increased interactive play/age-appropriate leisure skills, increased reciprocal communication, etc.
 7. Coordination with the school and/or early intervention program is critical. Collaboration between school and community providers is needed to coordinate treatment and to prevent duplication of services. This collaboration may take the form of phone calls, written communication logs, participation in team meetings (i.e., Individual Education Plan/Individual Family Service Plan [IEP/IFSP], Individual Plan of Service [IPOS], etc.).
 8. Services are able to be provided in the consumer's home and community, including centers and clinics.
 9. Symptoms are present in the early developmental period (symptoms may not fully manifest until social demands exceed limited capacities, or may be masked by learned strategies later in life).
 10. Symptoms cause clinically significant impairment in social, occupational, and/or other important areas of current functioning that are fundamental to maintain health, social inclusion, and increased independence.
 11. A qualified licensed practitioner recommends ABA services and the services are medically necessary for the consumer.
 12. Services must be based on the individual consumer and the parent's/guardian's needs and must consider the consumer's age, school attendance requirements, and other daily activities as documented in the IPOS. Families of minor consumers are expected to provide a minimum of eight hours of care per day on average throughout the month.

Clinical Practice Standards Manual

Medicaid Autism Spectrum Disorder Benefit Services

Revised: September 20, 2016; DWMHA Approved: February 21, 2017

- B. **Discharge Criteria:** Transition planning should occur at the time of intake into ABA Services. The aim of treatment, should always focus on discharge with the goal of transition to less restrictive settings with neuro-typical peers. ABA Discharge should occur if consumer is no longer eligible for benefit and/or any of the following apply:
1. The consumer has achieved treatment goals and less intensive modes of services are medically necessary and appropriate.
 2. The consumer is either no longer eligible for Medicaid or is no longer a State of Michigan resident.
 3. The consumer has not demonstrated measureable improvement and progress toward goals, and the predicted outcomes as evidenced by a lack of generalization of adaptive behaviors across different settings where the benefits of the ABA interventions are not able to be maintained or they are not replicable beyond the ABA treatment sessions through a period of six months.
 4. Targeted behaviors and symptoms are becoming persistently worse with ABA treatment over time or with successive authorizations.
 5. The consumer no longer meets the eligibility criteria as evidenced by use of valid evaluation tools administered by a qualified licensed practitioner.
 6. The consumer and/or parent/guardian is not able to meaningfully participate in the ABA services, and does not follow through with treatment recommendations to a degree that compromises the potential effectiveness and outcome of the ABA service.
 7. The consumer is lost to follow-up and all efforts made to contact service recipient and/or guardian have been unsuccessful, including mail and telephone attempts.

IV. Medicaid Autism Benefit Services:

A. Screening & Referral:

The American Academy of Pediatrics (AAP) endorses early identification of developmental disorders as being essential to the well-being of children and their families. Early identification of developmental disorders through screening by health care professionals should lead to further evaluation, diagnosis, and treatment. Early identification of a developmental disorder's underlying etiology may affect the medical treatment of the child and the parent's/guardian's intervention planning. Screening for ASD typically occurs during an EPSDT well child visit with the child's primary care provider (PCP). EPSDT well child visits may include a review of the child's overall medical and physical health, hearing, speech, vision, behavioral and developmental status, and screening for ASD with a validated and standardized screening tool. The EPSDT well child evaluation is also designed to rule out medical or behavioral conditions other than ASD, and include those conditions that may have behavioral implications and/or may co-occur with ASD. A full medical and physical examination must be performed before the child is referred for further evaluation.

Medicaid Autism Spectrum Disorder Benefit Services

Revised: September 20, 2016; DWMHA Approved: February 21, 2017

The PCP who screened the child for ASD and determined a referral for further evaluation was necessary will contact the Prepaid Inpatient Health Plan (PIHP) directly to arrange for a follow-up evaluation. The PCP must refer the child to the PIHP in the geographic service area for Medicaid beneficiaries. The PIHP will contact the child's parent(s)/guardian(s) to arrange a follow-up appointment for a comprehensive diagnostic evaluation and behavioral assessment. Each PIHP will identify a specific point of access for children who have been screened and are being referred for a diagnostic evaluation and behavioral assessment of ASD. If the PCP determines the child who screened positive for ASD is in need of occupational, physical, or speech therapy, the PCP will refer the child directly for the service(s) needed.

After a beneficiary is screened and the PCP determines a referral is necessary for a follow-up visit, the PIHP is responsible for the comprehensive diagnostic evaluation, behavioral assessment, ABA services (including ABA) for eligible Medicaid beneficiaries, and for the related EPSDT medically necessary Mental Health Specialty Services. Occupational therapy, physical therapy, and speech therapy for children with ASD that do not meet the eligibility requirements for developmental disabilities by the PIHP are covered by the Medicaid Health Plan or by Medicaid Fee-for-Service.

As ABA early intervention services are vital and we know that the earlier an individual accesses ABA, the increased chances of positive outcomes, DWMHA has a barrier-free access center that also screens individuals for diagnosis evaluations. These screenings are completed based on received requests from families.

B. Comprehensive Diagnosis Evaluation & Re-evaluation Service:

Accurate and early diagnosis of ASD is critical in ensuring appropriate intervention and positive outcomes. The comprehensive diagnostic evaluation must be performed before the child receives ABA services. The comprehensive diagnostic evaluation is a neurodevelopmental review of cognitive, behavioral, emotional, adaptive, and social functioning, and should include validated evaluation tools. Based on the evaluation, the practitioner determines the child's diagnosis, recommends general ASD treatment interventions, and refers the child for a behavior assessment. The provider who conducts the behavior assessment recommends more specific ASD treatment interventions. These evaluations are performed by a qualified licensed practitioner working within their scope of practice and who is qualified and experienced in diagnosing ASD. A qualified licensed practitioner includes: a physician with a specialty in psychiatry or neurology; a physician with a sub-specialty in developmental pediatrics, developmental-behavioral pediatrics or a related discipline; a physician with a specialty in pediatrics or other appropriate specialty with training, experience or expertise in ASD and/or behavioral health; a psychologist; an advanced practice registered nurse with training, experience, or expertise in ASD and/or behavioral health; a physician assistant with training, experience, or expertise in ASD and/or behavioral health; or a clinical social worker, working within their scope of practice, and is qualified and experienced in diagnosing ASD.

All Initial Comprehensive Diagnosis Evaluations must include a completed ADOS-2, ADIR, and DD-CGAS. Additional tools, such as cognitive and adaptive testing may be administered based on medical necessity. All Annual Comprehensive Diagnosis Re-Evaluations must be completed within 365 days of the previous MDHHS approval and must include a completed ADOS-2, and DD-CGAS. Additional tools, such as cognitive and adaptive testing may be administered based on medical necessity.

1.) EVALUATOR RESPONSIBILITIES:

Clinical Practice Standards Manual

Medicaid Autism Spectrum Disorder Benefit Services

Revised: September 20, 2016; DWMHA Approved: February 21, 2017

- i. The following are the specifications for the evaluator of a consumer referred with a suspected diagnosis of autism:

- 1.) Ensuring that evaluation is completed accurately, reliably, and efficiently.
- 2.) Ensuring that diagnostic appointments are available and entered into MH-WIN based on ability to meet timeline performance indicators. Appointments should only be entered into MH-WIN if the provider can meet indicators for services if the consumer is found eligible or pre-approval to evaluate and refer is received from DWMHA.
- 3.) Ensuring that consumer has active Medicaid coverage and is between the current target population age group.
- 4.) Completing diagnostic evaluations on consumers prior to entering ABA services, annually for redeterminations, and upon discharge from ABA services.
- 5.) Completing required demographic information and consent forms prior to delivering service.
- 6.) The evaluator must obtain consent to obtain and release information to Primary Care Physician from parent/guardian, and if consent is provided the evaluator to:
 - i. Consult with Primary Care Doctor and parent/guardian to identify whether the consumer has been assessed for several conditions whose symptoms may be associated with ASD, such as Fragile X Syndrome, tuberous sclerosis, lead toxicity, Fetal Alcohol Effect (FAE), Fetal Alcohol Syndrome (FAS), Attention Deficit Hyperactivity Disorder (ADHD), Traumatic Brain Injury (TBI), genetic syndromes, and neurological syndromes.
 - ii. Send the results of the diagnostic evaluation to consumer's Primary Care Physician if consent is obtained.
- 7.) Administration of the *Autism Diagnostic Observation Scale Second Edition (ADOS-2)*:
 - a) The module specific to the consumer's age and speech level is required. (*Toddler Module, Module 1, Module 2, Module 3, or Module 4 for ABA treatment population*)
 - b) A parent/guardian must be present at the time of administration.
 - c) Food/beverage included in administration must be approved by parent/guardian.
 - d) Compliance with the administration requirements outlined in the *ADOS-2 Manual* is required, which includes:
 - (i.) The tool is required to be scored directly after administration.
 - (ii.) The tool is required to be administered in an environment as free from distractions as possible to ensure validity and standardization in accordance with ADOS-2 manual recommendations.

Clinical Practice Standards Manual

Medicaid Autism Spectrum Disorder Benefit Services

Revised: September 20, 2016; DWMHA Approved: February 21, 2017

- (iii.) Evaluator must be trained in the delivery of the tool, including on-going refresher trainings as needed.
- 8.) Administration of the *Autism Diagnostic Interview - Revised* (ADI-R), which includes developmental family history interview that addresses all domains relevant to ASD that are outlined in the ASD operationalized diagnostic criteria indicated above (*social affective/communications skills, restricted repertoire*).
 - i. Compliance with the administration requirements outlined in the *ADIR Manual*
- 9.) Administration of the *Developmental Disabilities - Clinical Global Impression Severity Scale* (DD-CGAS) to rate symptom severity.
- 10.) Other tools may be used if medical necessity is identified to determine a diagnosis and medical necessity service recommendations. Other tools may include: cognitive/developmental tests such as the Mullen Scales of Early Learning, Wechsler Preschool and Primary Scale of Intelligence-IV (WPPSI-IV), Wechsler Intelligence Scale for Children-IV (WISC-IV), Wechsler Intelligence Scale for Children-V (WISC-V), or Differential Ability Scales-II (DAS-II); adaptive behavior tests such as Vineland Adaptive Behavior Scale-II (VABS-II), Adaptive Behavior Assessment System-III (ABAS-III), or Diagnostic Adaptive Behavior Scale (DABS), and/or; symptom monitoring such as Social Responsiveness Scale-II (SRS-II), Aberrant Behavior Checklist, or Social Communication Questionnaire (SCQ).
- 11.) The results of the evaluation must be appropriately delivered to families. It is strongly preferred that face-to-face Feedback Sessions occur with families to discuss the results of the evaluation and the next step for treatment options.

2.) **REPORTING REQUIREMENTS:**

Team is responsible for completing and submitting accurate reports within seven (7) days of evaluation and interpretation to the family completion that includes:

- i. Diagnostic evaluation tool results with separate area for specific item sub-scores.
- ii. Completion of specific evaluation *DWMHA ASD Benefit Comprehensive Diagnosis Evaluation and Re-evaluation Form* that includes:
 - 1.) ADOS-2 classification, module, and score, which may include Autism, Autism Spectrum Disorder, a differential diagnosis outside of one covered under this benefit, or not autism. DD-CGAS Score.
 - 2.) If Autism, Autism Spectrum Disorder is identified:
 - a. Identification of specific medical necessity criteria is met.
 - b. Documentation of all eligibility criteria components identified.

C. Applied Behavior Analysis Assessment & ABA Plan of Care
--

Clinical Practice Standards Manual

Medicaid Autism Spectrum Disorder Benefit Services

Revised: September 20, 2016; DWMHA Approved: February 21, 2017

Behavioral assessments must use a validated instrument and can include direct observational assessment, observation, record review, data collection, and analysis by a qualified provider. Examples of behavior assessments include function analysis and functional behavior assessments. The behavioral assessment must include the current level of functioning of the child using a validated data collection method. Behavioral assessments and ongoing measurements of improvement must include behavioral outcome tools. Examples of behavioral outcome tools include Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP), Assessment of Basic Language and Learning Skills revised (ABLLS-R), and Assessment of Functional Living Skills (AFLS).

- ii. An ABA Assessment is completed by a BCBA, BCaBA, LLP, QBHP Staff that:
 - 1.) Specifies service needs, including duration, setting, and skill levels;
 - 2.) Utilizes parent/guardian feedback; Providers are required to have families in leadership roles in the identification, planning, and implementation of services for their consumers with ASD.
 - 3.) Outlines behaviors and skills to be addressed and ABA interventions to be utilized to improve consumer's skills and functioning (*ABA goals may address a range from one specific targeted behavior (i.e., self-injurious behavior, yelling, etc.) to several complex behaviors (i.e., feeding, hygiene, communication)*);
 - 4.) Identifies at least one "*National Standards Project (NSP) Established Treatment*" per goal and objective within the treatment plan; and
 - 5.) Includes targeted behavior goals and specific steps for staff to take when responding to behaviors that support ABA treatment
 - 6.) Utilizes a validated instrument and can include direct observational assessment, observation, record review, data collection, and analysis by a qualified provider. Examples of behavior assessments include function analysis and functional behavior assessments. The behavioral assessment must include the current level of functioning of the child using a validated data collection method. Behavioral assessments and ongoing measurements of improvement must include one of the following behavioral outcome tools or a tool pre-approved by DWMHA:
 - a. *Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP)* – Administered by the BCBA, BCaBA, LLP, QBHP Staff at intake and every six (6) months thereafter for all consumers receiving ABA services.

-OR-

- b. *Assessment of Basic Language and Learning Skills Revised (ABLLS-R)* – Administered the BCBA, BCaBA, LLP, QBHP Staff at intake and every six (6) months thereafter for all consumers receiving ABA services.

-OR-

Clinical Practice Standards Manual

Medicaid Autism Spectrum Disorder Benefit Services

Revised: September 20, 2016; DWMHA Approved: February 21, 2017

- c. *Assessment of Functional Living Skills (AFLS)* – Administered the BCBA, BCaBA, LLP, QBHP Staff at intake and every six (6) months thereafter for all consumers receiving ABA services.
- iii. Treatment methodology will use an ethical, positive approach to any serious behaviors (e.g., self-injury, aggression). The use of punitive, restrictive, or intrusive interventions is prohibited during ABA, except in accordance with Policy. The use of restraints, seclusion, and aversive techniques are prohibited by MDHHS in all community settings.
- iv. Revisions are made to the *ABA Plan* frequently as identified by BCBA/LLP/QBHP.
- v. All ABA employees must know and understand the individual's *Person-Centered Plan* and *ABA Plan* for each consumer on their caseload. Training documentation must be maintained to identify staff training.
- vi. The ABA Treatment team will work collectively with Care Manager/Supports Coordinator/IPOS Case Holder and other treatment providers to identify integrated treatment plan goals and objectives so that the appropriate intensity of intervention is identified, outlined, coordinated and provided through treatment.
- vii. The ABA Treatment Team will assist and collaborate with the care manager/supports coordinator on transitional planning for consumers who no longer meet eligibility requirements or are no longer interested in receiving ABA treatment. Transition Planning should occur from the beginning of treatment.
- viii. A comprehensive ABA Plan of Care is required with the results from the ABA Assessment that will identify the specific ABA programming, including goals and objectives for the individual. Per the BACB Guidelines, all ABA Plans of Care should include:
 - 1) **Patient Information**
 - 2) **Reason for Referral**
 - 3) **Brief Background Information**
 - a. Demographics (name, age, gender, diagnosis)
 - b. Living situation
 - c. Home/school/work information
 - 4) **Clinical Interview**
 - a. Information gathering on problem behaviors, including developing operational definitions of primary area of concern and information regarding possible function of behavior
 - 5) **Review of Recent Assessments/Reports (file review)**
 - a. Any recent functional behavior assessment, cognitive testing, and/or progress reports

6) Assessment Procedures & Results

a. Brief description of assessments, including their purpose

- **INDIRECT ASSESSMENTS:**

- › Provide summary of findings for each assessment (graphs, tables, or grids)

- **DIRECT ASSESSMENTS:**

- › Provide summary of findings for each assessment (graphs, tables or grids)

b. Target behaviors are operationally defined, including baseline levels

c. Treatment Plan (Skill Acquisition – Comprehensive ABA)

a. Treatment setting

b. Instructional methods to be used

c. Operational definition for each skill

d. Describe data collection procedures

e. Proposed goals and objectives*

8) Treatment Plan (Focused ABA)

a. Treatment setting

b. Operational definition for each behavior and goal

c. Specify behavior management (that is, behavior reduction and/or acquisition) procedures:

- Antecedent-based interventions

- Consequence-based interventions

d. Describe data collection procedures

e. Proposed goals and objectives*

9) Parent/Caregiver Training

a. Specify parent training procedures

b. Describe data collection procedures

c. Proposed goals and objectives. *Each goal and objective must include:*

Clinical Practice Standards Manual

Medicaid Autism Spectrum Disorder Benefit Services

Revised: September 20, 2016; DWMHA Approved: February 21, 2017

- Current level (baseline)
- Behavior parent/caregiver is expected to demonstrate, including condition under which it must be demonstrated and mastery criteria (the objective or goal)
- Date of introduction
- Estimated date of mastery
- Specify plan for generalization
- Report goal as met, not met, modified (include explanation)

10) Number of Hours Requested

- a. Number of hours needed for each service
- b. Clinical summary that justifies hours requested
- c. Billing codes requested

11) Coordination of Care

12) Transition Plan

13) Discharge Plan

14) Crisis Plan

D. Applied Behavior Analysis Assessment
--

When a client displays problem behavior at a level that is disruptive to community inclusion, a functional assessment may be required. Functional assessment refers to the overall process of identifying the aspects of the environment that may contribute to the development and continued occurrence of problem behavior. That is, functional assessment is designed to identify where, when and the likely reasons why a problem behavior occurs. Such information is then directly incorporated into the problem behavior treatment plan in the form of a function-based intervention.

The functional assessment process typically includes multiple sources of information such as interviews with caregivers, structured ratings scales, and collection of direct observation data and consideration of potential medical conditions that may impact problem behavior.

Direct observation may take the form of assessment of ongoing interactions in the natural environment or the form of a functional analysis. Functional analysis refers to directly changing environmental events and evaluating the impact of those changes on the level of problem behavior via direct observation. Functional analyses can be complex and may require higher staffing ratios and more direction by the Behavior Analyst. (BACB Guidelines, 2012).

E. Applied Behavior Analysis Direct Service
--

Medicaid Autism Spectrum Disorder Benefit Services

Revised: September 20, 2016; DWMHA Approved: February 21, 2017

Applied Behavior Analysis (ABA) intervention for autism is to be customized to each consumer's skills, needs, interests, preferences, and family situation. ABA services are to be provided to consumers with ASD when medically necessary, in the least restrictive environment where the ultimate goal of treatment is to focus on improving core deficits in communication, social interaction, or restricted behaviors; all of which will impact fundamental deficits and help consumer develop greater functional skills and independence. The behavioral intervention should be provided at an appropriate level of intensity in an appropriate setting(s) for an appropriate period of time, depending on the needs of the consumer and their family within their community. Clinical determinations of service intensity, setting(s), and duration are to be designed to facilitate the consumer's goal attainment.

These supports may serve to reinforce skills or lessons taught in school, therapy or other settings, but are not intended to supplant services provided in school or other settings or to be provided when the consumer would typically be in school but for the parent's choice to home-school the consumer or parent's choice to decline school supports. ABA service providers are required to establish a system that ensures that services can be provided with no disruption to the consumer's scheduled school day. The provider should be skilled in implementing person-centered planning processes, which will include coordinating with other service provider entities, as well as coordinating with available community and natural supports.

Provider should be in contact with Case Manager / Supports Coordinator on a minimum of monthly basis to ensure service plan is accurate to meet current needs of family and collaborative treatment team is established. ABA Direct Services and Supervision must be provided at a rate of at least 75% of amount, scope, duration, and frequency identified and agreed-upon in IPOS. Quarterly ABA Plan updates on goals, objectives, progress and changes to amount/scope/duration/frequency are due from the ABA Provider to the IPOS case holder prior to the completion of the required 90-Day IPOS Review.

A. Applied Behavior Analysis Direct Service:

- i. Applied Behavior Analysis (ABA) is a scientific evidence-based practice that focuses on the analysis, design, implementation, and evaluation of social and other environmental modifications to produce meaningful changes in human behavior. 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. ABA focuses on treating the problems of the disorder by altering the individual's social and learning environments. (BACB Guidelines, 2012).
- ii. ABA Direct services can be provided in different modalities (*individual, groups, etc.*) and in different locations (*home, community, clinic, etc.*).
- iii. Behavior Technician Staff provide specific in-home, community-based, and/or clinic-based intervention activities for consumers diagnosed on the autism spectrum as identified in the Individualized Plan of Service (IPOS) and the *ABA Treatment Plan*.
- iv. If appropriate and identified in the plan of service, providers should deliver ABA services in a variety of settings to maximize generalization, maintenance, independence, and flexibility in the consumer's behaviors and skills.

Clinical Practice Standards Manual

Medicaid Autism Spectrum Disorder Benefit Services

Revised: September 20, 2016; DWMHA Approved: February 21, 2017

- v. ABA services are to be provided to increase developmentally-appropriate skills to facilitate a consumer's independence. These services must be provided directly to, or on behalf of, the consumer by training their parents/caregivers, Behavior Techs, and/or a BCaBA to deliver the ABA services. The ABA services must be provided under the supervision of a BCBA, other appropriately qualified licensed or limited licensed psychologist (LP, LLP), or master's prepared QBHP working within their scope of practice as identified in the staffing qualification section below.
 - vi. Behavior Technicians complete behavior tracking sheets and reports. ABA must include ongoing behavioral observation, assessment, data collection, and ongoing adjustments (*as indicated by BCBA/LLP/QBHP*).
- F. Parent/Guardian & Natural Supports Involvement:
- 1.) Providers are required to have families in leadership roles in the identification, planning, and implementation of services for their consumers with ASD. Living with a young person with ASD is likely to cause significant changes in lives of family members and, in most cases, the consumer will require assistance beyond services offered by professionals and direct staff. Services must be delivered in a manner that maximizes the benefit of treatment time and the time outside of treatment. Also, treatment should be provided that helps families maximize their own lives and the lives of their consumer with ASD.
 - 2.) A parent/guardian or caregiver must engage in treatment with their consumer to learn treatments and techniques that will assist the consumer in the generalization of behaviors outside of treatment hours.
- G. ABA services include a variety of behavioral interventions, which have been identified as evidence-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence. ABA services are designed to be delivered primarily in the home and in other community settings. Behavioral treatment intervention services include, but are not limited to, the following categories of evidence-based interventions:
1. Collecting information systematically regarding behaviors, environments, and task demands (e.g., shaping, demand fading, task analysis);
 2. Adapting environments to promote positive behaviors and learning while discouraging negative behaviors (e.g., naturalistic intervention, antecedent based intervention, visual supports, stimulus fading);
 3. Applying reinforcement to change behaviors and promote learning (e.g., reinforcement, differential reinforcement of alternative behaviors, extinction);
 4. Teaching techniques to promote positive behaviors, build motivation, and develop social, communication, and adaptive skills (e.g., discrete trial teaching, modeling, social skills instruction, picture exchange communication systems, pivotal response training, social narratives, self-management, prompting, chaining, imitation);

Clinical Practice Standards Manual

Medicaid Autism Spectrum Disorder Benefit Services

Revised: September 20, 2016; DWMHA Approved: February 21, 2017

5. Teaching parents/guardians to provide individualized interventions for their child, for the benefit of the child (e.g., parent/guardian implemented/mediated intervention);
6. Using typically developing peers (e.g., individuals who do not have ASD) to teach and interact with children with ASD (e.g., peer mediated instruction, structured play groups, peer social interaction training); and
7. Applying technological tools to change behaviors and teach skills (e.g., video modeling, tablet-based learning software).
8. ABA services provided must adhere to best practice standards and established interventions for ASD. Interventions that are identified as “*Established Treatments*” through the *National Standards Project* (NSP) or other ABA “established treatments” that focus on teaching specific adaptive skills. The NSP clinical trials can be found at: <http://www.nationalautismcenter.org/about/national.php> and include:
 - a. *Antecedent Package* – is often used in combination with other strategies and includes: choice, behavior chain interruption, priming, non-contingent reinforcement, errorless learning, incorporating echolalia and obsessive behaviors, prompting, antecedent based intervention, time delay, contriving motivational operations, environmental modifications of tasks, etc. Antecedent Package may be used to address both interfering and on-task behaviors.
 - b. *Behavioral Package* – is designed to decrease problem behaviors and teach functional alternative behaviors. Changing consequences is utilized. This includes: discrete trial training, differential reinforcement, functional communication training, contingency contracting, shaping, task analysis, token economy, instructional fading, generalization training, reinforcement, functional behavior analysis, response interruption/redirection, etc.
 - c. *Joint Attention Intervention* – Joint attention involves the interaction between individuals and is considered a pivotal skill for communication. Examples include: looking back and forth between a toy and the person who presented the toy, pointing to or showing objects of interest, or following someone else’s line of gaze.
 - d. *Modeling* – Often combined with reinforcement and prompting. Examples include: live modeling, video modeling, self-modeling.
 - e. *Naturalistic Teaching Strategies* – Naturalistic or incidental teaching strategies tend to have substantial generalization advantages. The environment is arranged to create interest on the part of the learner. The teaching interaction may begin with the learner initiating a request about a particular item/topic. Worker prompts an elaboration of that initiation, with greater elaboration resulting in gaining access to the desired item. These strategies increase initiation, build spontaneity, and shape complex and sophisticated communication responses.
 - f. *Pivotal Response Treatment* – Pivotal responses are those that, when trained, generally produce large collateral improvements in non-trained areas. Pivotal Responses include:

Clinical Practice Standards Manual

Medicaid Autism Spectrum Disorder Benefit Services

Revised: September 20, 2016; DWMHA Approved: February 21, 2017

reducing stimulus over selectivity, promoting motivation, promoting self-management, promoting self-initiation, and promoting empathy. PRT aims to increase a consumer's motivation to learn, monitor his own behavior, and initiate communication with others. Positive changes in these behaviors should have widespread effects on other behaviors.

- g. Schedules – Task lists of series of activities or steps to complete. Often supplemented with reinforcement. Helps improve self-regulation and assists with transitions. May involve visual supports or structured work systems.
- h. Self-management – Promotes independence by teaching behavior regulation through recording occurrence/nonoccurrence of target behavior and receiving reinforcement for doing so. Examples include: checklists, wrist counters, visual prompts, tokens.
- i. Story-based Intervention Package – Social Story describes a situation, skill, or concept in terms of relevant social cues, perspectives, and common responses in a specifically defined style and format. It explains what is happening and why it is occurring. It is primarily used for social behaviors and routines you want to increase and those situations that are new and anxiety-provoking. Stories are always personal, positive and short. Within an ABA program, Social Stories are used to help with transitions, school routines, appointments, and any other social behavior you want increased.
- j. Discrete Trial Training (DTT) - DTT is a style of teaching that uses a series of trials to teach each step of a desired behavior or response. Lessons are broken down into their simplest parts and positive reinforcement is used to reward correct answers and behaviors. Incorrect answers are ignored.
- k. Verbal Behavior Intervention (VBI) - VBI is a type of ABA that focuses on teaching verbal skills.

H. The following are **not** included in this benefit:

1. A there are a number of different treatments offered for individuals with ASD and there is limited daily time available to receive treatment and early intervention is key in outcomes, it is important for families to seek services that have been found to have the highest outcomes. Per the BACB Guidelines, studies have shown that an eclectic model, where ABA is combined with non-evidence-based treatment, is less effective than ABA alone.
2. Emerging practices identified by the NSP that have not been identified as being established as evidenced-based practices and are not included in the treatment.
3. Unestablished treatments or ineffective/harmful treatments identified by the NSP are not included in this benefit.
4. The provider must also be knowledgeable about modalities which either have been shown to lack positive effects or may endanger the person with ASD. It is expected that providers will not agree to participate in modalities which either are dangerous or have not been shown to have positive benefit for a consumer with ASD. It will be

essential to discuss the risks and possible benefits of treatment modalities, including those recommended by the agency and those proposed by families.

B. Applied Behavior Analysis Treatment Packages: Treatment packages are designed based on *MDHHS Policy and Behavior Analyst Certification Board Guidelines*.

i. **Focused Behavioral Intervention** - Focused behavioral intervention is provided an average of 5-15 hours per week.

a. **Per the BACB:** Focused ABA refers to treatment provided directly to the client for a limited number of behavioral targets. It is not restricted by age, cognitive level, or co-occurring conditions.

Focused ABA treatment may involve increasing socially appropriate behavior (for example, increasing social initiations) or reducing problem behavior (for example, aggression) as the primary target. Even when reduction of problem behavior is the primary goal, it is critical to also target increases in appropriate alternative behavior, because the absence of appropriate behavior is often the precursor to serious behavior disorders. Therefore, individuals who need to acquire skills (for example, communication, tolerating change in environments and activities, self-help, social skills) are also appropriate for Focused ABA.

Focused ABA plans are appropriate for individuals who (a) need treatment only for a limited number of key functional skills or (b) have such acute problem behavior that its treatment should be the priority.

When prioritizing the order in which to address multiple treatment targets, the following should be considered:

Behavior that threatens the health or safety of the client or others or that constitute a barrier to quality of life (for example, severe aggression, self-injury, property destruction, or noncompliance);

Absence of developmentally appropriate adaptive, social, or functional skills that are fundamental to maintain health, social inclusion, and increased independence (for example, toileting, dressing, feeding, and compliance with medical procedures).

When the focus of treatment involves the reduction of severe problem behavior, the Behavior Analyst will determine which situations are most likely to precipitate problem behavior and, based on this information, begin to identify its potential purpose (or “function”). This may require conducting a functional analysis procedure to empirically demonstrate the function of the problem behavior. The results enable the Behavior Analyst to develop the most effective treatment protocol. When the function of the problem behavior is identified, the Behavior Analyst will design a treatment plan that alters the environment to reduce the motivation for problem behavior and/ or establish a new and more appropriate behavior that serves the same function and therefore “replaces” the problem behavior.

ii. **Comprehensive Behavioral Intervention** - Comprehensive behavioral intervention is provided an average of 16-25 hours per week

- a. **Per the BACB:** Comprehensive ABA refers to treatment of the multiple affected developmental domains, such as cognitive, communicative, social, emotional, and adaptive functioning. Maladaptive behaviors, such as noncompliance, tantrums, and stereotypy are also typically the focus of treatment. Although there are different types of comprehensive treatment, one example is early intensive behavioral intervention where the overarching goal is to close the gap between the client's level of functioning and that of typically developing peers. Initially, this treatment model typically involves 1:1 staffing and gradually includes small-group formats as appropriate. Comprehensive treatment may also be appropriate for older individuals diagnosed with ASD, particularly if they engage in severe or dangerous behaviors across environments.

F. Behavior Technician Direction and Observation

Behavioral observation and direction is the clinical direction and oversight provided by a qualified provider to a lower level provider based on the required provider standards and qualifications regarding the provision of services to a child. The qualified provider delivers face-to-face observation and direction to a lower level provider regarding developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for each child. This service is for the direct benefit of the child and provides a real time response to the intervention to maximize the benefit for the child. It also informs of any modifications needed to the methods to be implemented to support the accomplishment of outcomes in the behavioral plan of care.

- 1.) One hour of billable direction/observation from BCBA/LLP/QBHP per every ten (10) hours of direct ABA service delivered to the consumer required for Behavior Technicians. Two hours per every 10 hours of direct is recommended, which includes both direct billable and non-billable service oversight of case. The following are a breakdown of BACB Direct and Indirect Direction/Observation & supervision activities:

a. Direct Supervision Activities

- Directly observe treatment implementation for potential program revision
- Monitor treatment integrity to ensure satisfactory implementation of treatment protocols
- Directing staff and/or caregivers in the implementation of new or revised treatment protocols (client present)

b. Indirect Supervision Activities

- Develop treatment goals, protocols, and data collection systems
- Summarize and analyze data
- Evaluate client progress towards treatment goals
- Adjust treatment protocols based on data
- Coordination of care with other professionals

Clinical Practice Standards Manual

Medicaid Autism Spectrum Disorder Benefit Services

Revised: September 20, 2016; DWMHA Approved: February 21, 2017

- Crisis intervention
 - Report progress towards treatment goals
 - Develop and oversee transition/discharge plan
 - Review client progress with staff without the client present to refine treatment protocols
 - Directing staff and/or caregivers in the implementation of new or revised treatment protocols (client absent)
- 2.) All staff must be trained properly in the specific interventions included in the *ABA Plan* of the consumer that they are working with.
 - 3.) BCBA/LLP/QBHP to schedule regular visits with parents/guardian or caregivers identified in the PCP and behavior technicians to review program effectiveness, make observations, etc.
 - 4.) BCBA/LLP/QBHP reviews data and reports submitted by Behavior Technician team.
 - 5.) BCBA/LLP/QBHP must be able to provide immediate feedback and training to the Behavior Technician staff to directly impact services on the case. BCBA/LLP/QBHP must be in a role that allows appropriate direction/observation to be delivered.

G. Parent and Caregiver Training:

Parent and Caregiver training should be part of every ABA Benefit Service Plan. Parent and Caregiver Training is vital to the generalization of behavior outside of treatment hours. Parent and Guardian Training is key to assisting the family in understanding ABA and the intensity of service and how to implement interventions and reduce behaviors that may contribute to a added family stress and reduced community inclusion. Training of parents and other caregivers usually involves a systematic, individualized curriculum on the basics of ABA. It is common for treatment plans to include several objective and measurable goals for parents and other caregivers. Training emphasizes skills development and support so that caregivers become competent in implementing treatment protocols across critical environments. Parent and Caregiver training can also assist in relationship development in the family and increased appropriate play and interaction with siblings.

Clinical Practice Standards Manual

Medicaid Autism Spectrum Disorder Benefit Services

Revised: September 20, 2016; DWMHA Approved: February 21, 2017

V. Service Authorization Range

HCPCS Codes	Code Type	Service Provided	Staff	Comprehensive (Higher Level of Care; TG Modifier on Direct)	Focused (Lower Level of Care; TF Modifier on Direct)
				Required Authorization Range*	Required Authorization Range*
H0031 U5	Encounter	<i>Initial Eligibility Evaluation: ADIR/Developmental Interview, ADOS-2, and DD-CGAS.</i>	Qualified Licensed Practitioner	One unit prior to entering the benefit	One unit prior to entering the benefit
H0031 U5 AN	Encounter	<i>Annual Re-evaluation: ADOS-2 & DD-CGAS Only</i>	Qualified Licensed Practitioner	One unit authorized annually	One unit authorized annually
0359T U5	Encounter	<i>Assessment: ABLLS-R or VB-MAPP or AFLS</i>	Behaviorist	One unit every 6 months	One unit every 6 months
0368X U5	30 minute	<i>Direction/Observation of Behavior Technician with Child Present</i>	Behaviorist	1.75 - 2.5 hours per week (7-10 units)	0.5 - 1.5 hours per week (2-6 units)
0364X U5	30 minute	<i>ABA Direct Service</i>	Behavior Technician	31-50 (16-25 hours) per week	10-30 units (5-15 hours) per week
0366X U5	30 minute	<i>Group ABA Direct Service</i>	Behavior Technician		
0373T U5	60 minute / 30 minute	<i>ABA Direct Service (2:1 Staffing)*</i>	Behavior Technician		
0362X U5	30 minute	<i>Functional Behavior Assessment (FBA)</i>	Behaviorist	As medical / clinical necessity	
0372T U5	Encounter	<i>Social Skills Group</i>	Behaviorist	As medical / clinical necessity	
0370T U5	Encounter	<i>Family Training</i>	Behaviorist	As medical / clinical necessity	
0371T U5	Encounter	<i>Group Family Training</i>	Behaviorist	As medical / clinical necessity	
96101 U5	60 Minute	<i>Psychological or Adaptive Testing</i>	Psychologist	As medical / clinical necessity	
90791 U5	Encounter	<i>Psychiatric Diagnosis Evaluation</i>	Psychiatrist	As medical / clinical necessity	
90792 U5	Encounter	<i>Psychiatric Diagnosis Evaluation</i>	Psychiatrist	As medical / clinical necessity	
90833 U5	30 Minute	<i>Psychiatric Add-On Code</i>	Psychiatrist	As medical / clinical necessity	
90836 U5	45 Minute	<i>Psychiatric Add-On Code</i>	Psychiatrist	As medical / clinical necessity	
90838 U5	60 Minute	<i>Psychiatric Add-On Code</i>	Psychiatrist	As medical / clinical necessity	
90785 U5	Add-On	<i>Psychiatric Add-On Code</i>	Psychiatrist	As medical / clinical necessity	
96102 U5	60 Minute	<i>Psychological Testing Administered by a Technician</i>	Social Worker	As medical / clinical necessity	
96118 U5	60 Minute	<i>Neuropsychological Testing</i>	Psychologist	As medical / clinical necessity	
96119 U5	60 Minute	<i>Neuropsychological Testing</i>	Psychologist	As medical / clinical necessity	

*Must have Behavior Treatment Review Committee Approval

These are recommendations, more or less may be authorized based on medical necessity

VI. Staffing:

ABA services are highly specialized services that require specific qualified providers that are available within PIHP/CMHSP provider networks and have extensive experience providing specialty mental health and behavioral health services. It should be noted that other licensed professionals may have ABA included within their particular scope of training and competence. ABA services within the ABA Benefit must be provided under the direction of a BCBA, another appropriately qualified LP or LLP, or a Master's prepared QBHP. These services must be provided directly to, or on behalf of, the child by training their parents/guardians, behavior technicians, and BCaBAs to deliver the behavioral interventions. The BCBA and other qualified providers are also responsible for communicating progress on goals to parents/guardians minimally every three to six months, clinical skill development and supervision of BCaBA, QBHP, and behavior technicians, and collaborating with support coordinators/case managers and the parents/guardians on goals and objectives with participation in development of the IPOS that includes the behavioral plan of care.

The Behavior Analysis Certification Board (BACB) recognizes and credentials four distinct practitioner levels. Each level has specific training (initial and continuing education), education, and experience, supervision, ethical, and examination requirements. Each level has a unique and specific scope of practice. High School or Associate level staff can be credentialed as Registered Behavior Technicians (RBT). Bachelor level staff can be credentialed as Board Certified Assistance Behavior Analysts (BCaBA). Master level staff can be credentialed as Board Certified Behavior Analysts (BCBA) and doctoral level staff can be credentialed as Board Certified Behavior Analysts – Doctoral (BCBA-D). State licensure, where applicable, is outside of Board Certification and specific to the State the individual is practicing in.

A. Staffing Requirements within the ABA Benefit:

1. **ABA Supervisors:** Caseload size 6-24 individuals depending on level of treatment and staffing support.
 - i. **Board Certified Behavior Analyst-Doctorate (BCBA-D) or BCBA**
 - o Services Provided: Behavioral assessment, behavioral treatment, and behavioral observation and direction.
 - o License/Certification: Current certification as a BCBA through the BACB. The BACB is the national entity accredited by the National Commission for Certifying Agencies (NCCA).
 - o Education and Training: Minimum of a master's degree from an accredited institution conferred in a degree program in which the candidate completed a BACB approved course sequence.
 - ii. **Licensed Psychologist (LP):** Must be certified as a BCBA by September 30, 2020
 - o Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction.
 - o License/Certification: LP means a doctoral level psychologist licensed by the State of Michigan. Must complete all coursework and experience requirements.

Clinical Practice Standards Manual

Medicaid Autism Spectrum Disorder Benefit Services

Revised: September 20, 2016; DWMHA Approved: February 21, 2017

- o Education and Training: Minimum doctorate degree from an accredited institution. Works within their scope of practice and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented coursework at the graduate level from an accredited university in at least three of the six following areas:
 1. Ethical considerations.
 2. Definitions & characteristics and principles, processes & concepts of behavior.
 3. Behavioral assessment and selecting interventions outcomes and strategies.
 4. Experimental evaluation of interventions.
 5. Measurement of behavior and developing and interpreting behavioral data.
 6. Behavioral change procedures and systems supports.
- o A minimum of one year experience in treating children with ASD based on the principles of behavior analysis. Works in consultation with the BCBA to discuss the caseload, progress, and treatment of the child with ASD.
- iii. **LLP:** Must be certified as a BCBA by September 30, 2020
 - o Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction.
 - o License/Certification: LLP means a doctoral or master level psychologist licensed by the State of Michigan. Limited psychologist master's limited license is good for one two-year period. Must complete all coursework and experience requirements.
 - o Education and Training: Minimum of a master's or doctorate degree from an accredited institution. Works within their scope of practice and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented coursework at the graduate level from an accredited university in at least three of the six following areas:
 1. Ethical considerations.
 2. Definitions & characteristics and principles, processes & concepts of behavior.
 3. Behavioral assessment and selecting interventions outcomes and strategies.
 4. Experimental evaluation of interventions.
 5. Measurement of behavior and developing and interpreting behavioral data.
 6. Behavioral change procedures and systems supports.

Clinical Practice Standards Manual

Medicaid Autism Spectrum Disorder Benefit Services

Revised: September 20, 2016; DWMHA Approved: February 21, 2017

- o A minimum of one year experience in treating children with ASD based on the principles of behavior analysis. Works in consultation with the BCBA to discuss the progress and treatment of the child with ASD.

iv. **BCaBA**

- o Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction.

- o License/Certification: Current certification as a BCaBA through the BACB. The BACB is the national entity accredited by the NCCA.

- o Education and Training: Minimum of a bachelor's degree from an accredited institution conferred in a degree program in which the candidate completed a BACB approved course sequence.

- o Other Standard: Works under the supervision of the BCBA.

v. **QBHP**: Must be certified as a BCBA by September 30, 2020

- o Services Provided: Behavioral assessment, behavioral treatment, and behavioral observation and direction.

- o License/Certification: A license or certification is not required, but is optional.

- o Education and Training: QBHP must meet one of the following state requirements:

- Must be a physician or licensed practitioner with specialized training and one year of experience in the examination, evaluation, and treatment of children with ASD.
- Minimum of a master's degree in a mental health-related field or BACB approved field from an accredited institution with specialized training and one year of experience in the examination, evaluation, and treatment of children with ASD. Works within their scope of practice, works under the supervision of the BCBA, and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented coursework at the graduate level from an accredited university in at least three of the six following areas:
 1. Ethical considerations.
 2. Definitions & characteristics and principles, processes & concepts of behavior.
 3. Behavioral assessment and selecting interventions outcomes and strategies.
 4. Experimental evaluation of interventions.
 5. Measurement of behavior and developing and interpreting behavioral data.
 6. Behavioral change procedures and systems supports.

Clinical Practice Standards Manual

Medicaid Autism Spectrum Disorder Benefit Services

Revised: September 20, 2016; DWMHA Approved: February 21, 2017

2. Behavior Technician

- o Services Provided: Behavioral intervention.
- o License/Certification: A license or certification is not required.
- o Education and Training: Will receive BACB Registered Behavior Technician (RBT) training conducted by a professional experienced in ABA services (BCBA, BCaBA, LP, LLP, and/or QBHP), but is not required to register with the BACB upon completion in order to furnish services.
- o Works under the supervision of the BCBA or other professional (BCaBA, LP, LLP or QBHP) overseeing the behavioral plan of care, with minimally one hour of clinical observation and direction for every 10 hours of direct treatment.
- o Must be at least 18 years of age; able to practice universal precautions to protect against the transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedure, and to report on activities performed; and be in good standing with the law (i.e., not a fugitive from justice, a convicted felon who is either under jurisdiction or whose felony relates to the kind of duty to be performed, or an illegal alien). Must be able to perform and be certified in basic first aid procedures and is trained in the IPOS/behavioral plan of care utilizing the person-centered planning process.

VII. Staffing Compliance Chart

Applied Behavior Analysis (ABA) Benefit Staffing

**For staff who served in multiple staffing categories (ie - QBHP is now a BCBA) documentation for all categories must be provided when providing services to DWMHA consumer.*

Discovery Evidence (Performance Measures)

Document Reviewed

Qualified Licensed Professional

State of Michigan Licensure	<i>1) Copy of State of Michigan License that covers date of hire; AND 2) Current Copy of State of Michigan License. License MUST be in one of the following areas: Physician, Psychology, Advanced Practice Registered Nurse; Physician Assistant, Master's Social Worker with expiration in the future</i>
Degree Requirements	<i>Degree Certificate documenting Master Degree or Doctoral Degree in a) Medicine with specialty in psychiatry or neurology, sub-specialty in developmental pediatrics, developmental -behavioral pediatrics, pediatrics or related discipline; b) Psychology; c) Advanced practice registered nurse; d) Clinical Social Work (Non-Macro)</i>
Experience	<i>Resume, Curriculum Vitae, employer letter, transcripts, job description, or other documentation that clearly identifies training, experience, or expertise in ASD and/or behavioral health</i>

Clinical Practice Standards Manual

Medicaid Autism Spectrum Disorder Benefit Services

Revised: September 20, 2016; DWMHA Approved: February 21, 2017

BCBA or BCBA-D

Date of Hire	<i>Employer Offer Letter, HR Documentation, or other Documentation</i>
Criminal Background Checks	<i>1) Criminal Background Check with date prior to the start of service delivery; AND 2) Criminal Background Check completed within the previous 365 days</i>
Board Certification	<i>1) Copy of Board Certification from the BACB that covers date of hire; AND 2) Current Copy of Board Certification with expiration in the future</i>

BCaBA

Date of Hire	<i>Employer Offer Letter, HR Documentation, or other Documentation</i>
Criminal Background Checks	<i>1) Criminal Background Check with date prior to the start of service delivery; AND 2) Criminal Background Check completed within the previous 365 days</i>
Board Certification	<i>1) Copy of Board Certification from the BACB that covers date of hire; AND 2) Current Copy of Board Certification with expiration in the future</i>
Supervision	<i>Supervision documentation that includes name of supervising BCBA.</i>

Licensed Psychologist / Limited Licensed Psychologist

State of Michigan Licensure	<i>1) Copy of State of Michigan Psychology License that covers date of hire; AND 2) Current Copy of State of Michigan Psychology License</i>
Date of Hire	<i>Employer Offer Letter, HR Documentation, or other Documentation</i>
Criminal Background Checks	<i>1) Criminal Background Check with date prior to the start of service delivery; AND 2) Criminal Background Check completed within the previous 365 days</i>
Degree Requirements	<i>Degree Certificate documenting Master Degree or Doctoral Degree in Psychology</i>
Master Level Coursework	<i>Graduate Level Transcripts identifying completion of 3 of the 6 required BCBA Courses: 1) Ethical Considerations; 2) Definitions & Characteristics and principles, processes & concepts of behavior; 3) Behavioral assessment and selecting interventions outcomes and strategies; 4) Experimental evaluation of interventions; 5) Measurement of behavior and developing and interpreting behavioral data; 6) Behavioral change procedures and systems supports. *If transcripts do not specifically identify course as indicated above, file MUST have course syllabi OR BACB document indicating BACB course approval from specific institution.</i>
Experience	<i>Resume, Curriculum Vitae, employer letter, job description, or other documentation that clearly identifies ONE year of experience in treating children with ASD based on the principles of behavior analysis</i>
Supervision	<i>Supervision documentation that includes name of supervising BCBA, hours of supervision provided, and type of supervision provided in BACB recommended format.</i>

Qualified Behavior Health Professional

Date of Hire	<i>Employer Offer Letter, HR Documentation, or other Documentation</i>
Criminal Background Checks	<i>1) Criminal Background Check with date prior to the start of service delivery; AND 2) Criminal Background Check completed within the previous 365 days</i>
Degree Requirements	<i>Degree Certificate documenting Master Degree or Doctoral Degree in a mental health field or field approved through the BACB.</i>
Master Level Coursework	<i>Graduate Level Transcripts identifying completion of 3 of the 6 required BCBA Courses: 1) Ethical Considerations; 2) Definitions & Characteristics and principles, processes & concepts of behavior; 3) Behavioral assessment and</i>

Clinical Practice Standards Manual

Medicaid Autism Spectrum Disorder Benefit Services

Revised: September 20, 2016; DWMHA Approved: February 21, 2017

	<i>selecting interventions outcomes and strategies; 4) Experimental evaluation of interventions; 5) Measurement of behavior and developing and interpreting behavioral data; 6) Behavioral change procedures and systems supports. *If transcripts do not specifically identify course as indicated above, file MUST have course syllabi OR BACB document indicating BACB course approval from specific institution.</i>
Experience	<i>Resume, Curriculum Vitae, employer letter, job description, or other documentation that clearly identifies ONE year of experience in the examination, evaluation and treatment of children with ASD.</i>
Supervision	<i>Supervision documentation that includes name of supervising BCBA, hours of supervision provided, and type of supervision provided in BACB recommended format.</i>

Behavior Technician

Date of Hire	<i>Employer Offer Letter, HR Documentation, or other Documentation</i>
Criminal Background Checks	<i>1) Criminal Background Check with date prior to the start of service delivery; AND 2) Criminal Background Check completed within the previous 365 days</i>
Age	<i>Copy of Driver's License, state identification, or other documentation indicating age at the time of hire</i>
Communicable Disease Prevention Training	<i>Universal Precautions Training certificate, transcript, or other documentation with completion date prior to the service delivery start date.</i>
First Aid Training	<i>First Aid Training certificate, transcript, or other documentation with completion date prior to the service delivery start date.</i>
IPOS/ Behavioral Plan of Care Training	<i>IPOS Training certificate, transcript, or other documentation with completion date prior to the service delivery start date and at each quarterly IPOS revision dates.</i>
Ability to communicate expressively & receptively in order to follow IPOS requirements, emergency procedures, and report on activities performed	<i>College/university diploma, BCBA verification statement, or Job Description with skill requirement.</i>
Registered Behavior Technician Training	<i>RBT Training Transcripts with 40 hours of BACB RBT Task List Objectives (A-01 through F-05) clearly identified with completion dates prior to the delivery of services after 1/1/16</i>

VIII. References:

1. The Behavior Analyst Certification Board (BACB). (2014) *Applied Behavior Analysis Treatment of Autism Spectrum Disorder. Practice Guidelines for Healthcare Funders and Managers*. Second Edition. <http://bacb.com/asd-practice-document/>
2. The Michigan Department of Health and Human Services (MDHHS). *Medical Service Administration Bulletin 15-59. Coverage of Autism Services for Individuals Under 21 Years of Age*. <http://dwmha.com/programs-services/autism/autism-resource-documents/>

Clinical Practice Standards Manual

Medicaid Autism Spectrum Disorder Benefit Services

Revised: September 20, 2016; DWMHA Approved: February 21, 2017

3. Detroit Wayne Mental Health Authority (DWMHA) *Medicaid Autism Benefit Scope of Services*.
<http://dwmha.com/programs-services/autism/autism-resource-documents/>

4. Detroit Wayne Mental Health Authority (DWMHA) *Medicaid Autism Benefit Telepractice Guide*.
http://dwmha.com/files/9914/6886/8828/DWMHA_ASD_Benefit_Telepractice_Guide_6.16.16.pdf

Management of Adults with Depression

1. Eligibility Criteria
 - a. Adults aged 18 years and older;
 - b. Males and females;
 - c. No exclusions due to comorbidity/co-occurring disorders.
2. Screening for depression
 - a. All eligible persons shall be screened for depression utilizing the Patient Health Questionnaire for depression (PHQ-9) at the point of intake into the specialty behavioral health services.
 - b. Screening with the PHQ-9 should also be repeated should symptoms suggest the presence of depression.
 - c. The PHQ-9 is a self-scoring tool administered by the consumer. Scores greater than or equal to 10 indicate a significant risk for major depression and require a full assessment for the disorder.
3. Assessment for Major Depression
 - a. Scores of 5, 10, 15 and 20 represent mild, moderate, moderately severe, and severe depression.
 - i. Presence of active symptoms for over a month warrant active treatment.
 - b. The assessment for the major depression must be completed and documented; the PHQ-9 does not substitute for a clinical assessment.
 - c. Formal assessment for suicide risk is required and must be documented in the medical record.
 - d. Assess for comorbid conditions that may impact treatment recommendations.
 - e. Utilize the PHQ-9 scores, and assessment findings to identify target symptoms for treatment and monitoring.
4. Treatment and follow-up
 - a. Educate the consumer and supports about treatment options, self-management and supports, lifestyle changes including nutrition and exercise, coping skills and spiritual support.
 - b. Treatment planning must be individualized and person-centered.
 - c. If initiating antidepressants, ensure that informed consent has been documented.
 - i. Make efforts to draw baseline laboratory studies and follow-up as clinically appropriate.
 - ii. Educate consumer about side effects, including those following of abrupt discontinuation.
 - d. Ensure the appropriate frequency of follow-up contacts, which should more frequent during the initiation of treatment, or following increases or tapering of medications.
5. Monitoring
 - a. The PHQ-9 should be administered upon each follow-up visit.
 - b. Document changes to target symptoms
 - c. Lack of significant response to treatment should result in an adjustment to treatment.

- i. Consider changes to, or initiation of medications.
 - ii. Consider changes to, or initiation of psychotherapy, e.g. frequency.
 - iii. Consider adherence, diagnosis, psychosocial stressors, other causes for exacerbation of symptoms.
- d. Treat to remission (PHQ-9 less than 10).
 - i. Continue to treat for at least 9-12 months from the initiation of the treatment.
- e. Continue to use the PHQ-9 to monitor for any exacerbation/recurrence of symptoms at least annually.

Measurement of the PHQ-9 Tool In Major Depression

Measure Details

Measure Steward: DWMHA Quality Management

Measure Description: Adults age 18 and older for specialty behavioral healthcare populations should:

1. All have a PHQ-9 screening completed at intake.
2. Patients diagnosed with Major Depression (PHQ-9 score greater than or equal to 10) should have PHQ-9 scores measured and documented each visit for therapeutic interventions.

Numerator Statement:

1. Adult patients age 18 and older with a screening PHQ-9 at intake within the measurement period.
2. Adult patients age 18 and older with a diagnosis of Major Depression (PHQ-9 score greater than or equal 10) with a PHQ-9 within a 3 month measurement period.

Denominator Statement:

1. Adult patients aged 18 and older with an intake assessment within the measurement period.
2. Adult patients age 18 and older with a diagnosis of Major Depression within a 3 month measurement period.

Exclusions: Patients who die, are permanent residents of a nursing facility, or enter a hospice program are excluded from this measure.

Risk Adjustment: No

SCREENING MEMBERS WITH SCHIZOPHRENIA AND BIPOLAR DISORDER ON ATYPICAL ANTIPSYCHOTIC MEDICATIONS FOR DIABETES

1. Eligibility Criteria:
 - a. Adults 18-64 years old with schizophrenia and bipolar disorder on atypical antipsychotic medications or being started on atypical antipsychotic medication(s)
 - b. Males and females;
 - c. Exclusions: Enrollee/members already diagnosed with diabetes and enrollee/members with schizophrenia and bipolar disorder for which atypical antipsychotic medications are not dispensed.
2. Screening for diabetes:
 - a. HbA1c or fasting blood sugar(FBS) should be ordered or performed prior to the first prescription of atypical antipsychotic medication(s) for new patients not currently on atypical antipsychotic medication(s);
 - b. For enrollee/members currently on atypical antipsychotic medications who have never been screened, HbA1c or FBS will be ordered or drawn at next medication review appointment.
3. Treatment and Follow-up:
 - a. Educate the enrollee/member and supports about treatment options, self-management and supports, lifestyle changes including nutrition and exercise, coping skills and spiritual support;
 - b. Treatment planning must be individualized and person-centered;
 - c. Follow up will be done with enrollee/member within fourteen (14) days of labs being ordered to ensure enrollee/member has had it drawn. If no, discuss importance and address any barriers.
 - d. If initiating atypical antipsychotic medications, ensure that informed consent has been documented.
 - i. Make efforts to draw baseline laboratory studies and follow-up as clinically appropriate.
 - ii. Educate enrollee/members about side effects, including those following abrupt discontinuation.
 - iii. Address any side effects at each appointment and adjust or change medications as needed to ensure compliance.
 - e. Ensure the appropriate frequency of follow-up contacts, which should be more frequent during the initiation of treatment, or following increases or tapering of medications.
 - f. Enrollee/members on atypical antipsychotics will be weighed prior to starting atypical antipsychotics and at all subsequent medication review appointments.
 - g. For enrollee/members with HbA1c greater than 5.7% provide referral to a primary care provider if enrollee/member does not have one and assist in obtaining an appointment with primary care provider for follow up and sharing of lab results;
 - h. For enrollee/member with fasting blood sugar (FBS) greater than or equal to 100 mg/DL provide referral to a primary care provider if enrollee/member does not have one and assist in obtaining an appointment with primary care provider for follow up and sharing of lab results;

- i. For enrollee/member who gains 5% or more of their initial weight at any time during therapy, consider switching to a different antipsychotic medication;
 - j. Ensure enrollee member has an assigned primary care provider and is obtaining regular medical care;
 - k. Follow up with enrollee/member to ensure that they kept appointment with primary care provider. If no, educate on importance and address any barriers;
 - l. For enrollee/members with normal baseline tests, it is recommended that HbA1c or FBS are repeated at 12 weeks after initiation of treatment; and annually thereafter.
4. Monitoring
- a. HEDIS measure diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications to monitor compliance with lab draws will be run quarterly.
 - b. Treatment chart audits to validate labs ordered, weights and BMI done as recommended in clinical guidelines.
 - c. Clinicians should Document changes to target symptoms
 - d. Lack of significant response to treatment should result in an adjustment to treatment.

Clinical guidelines based on the following articles:

1. American Heart Association article, "Symptoms and Diagnosis of Metabolic Syndrome," September 15, 2016.
2. American Diabetes Association article, "Metabolic Screening after the American Diabetes Association's Consensus Statement on Antipsychotic Drugs and Diabetes," June 2009.
3. International Journal of Endocrinology article, "An Overview of Diabetes Management in Schizophrenia Patients: Office Based Strategies for Primary Care Practitioners and Endocrinologists,"

SCREENING MEMBERS WITH SCHIZOPHRENIA AND BIPOLAR DISORDER ON ATYPICAL ANTIPSYCHOTIC MEDICATIONS FOR DIABETES

1. Eligibility Criteria:
 - a. Adults 18-64 years old with schizophrenia and bipolar disorder on atypical antipsychotic medications or being started on atypical antipsychotic medication(s)
 - b. Males and females;
 - c. Exclusions: Enrollee/members already diagnosed with diabetes and enrollee/members with schizophrenia and bipolar disorder for which atypical antipsychotic medications are not dispensed.
2. Screening for diabetes:
 - a. HbA1c or fasting blood sugar(FBS) should be ordered or performed prior to the first prescription of atypical antipsychotic medication(s) for new patients not currently on atypical antipsychotic medication(s);
 - b. For enrollee/members currently on atypical antipsychotic medications who have never been screened, HbA1c or FBS will be ordered or drawn at next medication review appointment.
3. Treatment and Follow-up:
 - a. Educate the enrollee/member and supports about treatment options, self-management and supports, lifestyle changes including nutrition and exercise, coping skills and spiritual support;
 - b. Treatment planning must be individualized and person-centered;
 - c. Follow up will be done with enrollee/member within fourteen (14) days of labs being ordered to ensure enrollee/member has had it drawn. If no, discuss importance and address any barriers.
 - d. If initiating atypical antipsychotic medications, ensure that informed consent has been documented.
 - i. Make efforts to draw baseline laboratory studies and follow-up as clinically appropriate.
 - ii. Educate enrollee/members about side effects, including those following abrupt discontinuation.
 - iii. Address any side effects at each appointment and adjust or change medications as needed to ensure compliance.
 - e. Ensure the appropriate frequency of follow-up contacts, which should be more frequent during the initiation of treatment, or following increases or tapering of medications.
 - f. Enrollee/members on atypical antipsychotics will be weighed prior to starting atypical antipsychotics and at all subsequent medication review appointments.
 - g. For enrollee/members with HbA1c greater than 5.7% provide referral to a primary care provider if enrollee/member does not have one and assist in obtaining an appointment with primary care provider for follow up and sharing of lab results;
 - h. For enrollee/member with fasting blood sugar (FBS) greater than or equal to 100 mg/DL provide referral to a primary care provider if enrollee/member does not have one and assist in obtaining an appointment with primary care provider for follow up and sharing of lab results;

- i. For enrollee/member who gains 5% or more of their initial weight at any time during therapy, consider switching to a different antipsychotic medication;
 - j. Ensure enrollee member has an assigned primary care provider and is obtaining regular medical care;
 - k. Follow up with enrollee/member to ensure that they kept appointment with primary care provider. If no, educate on importance and address any barriers;
 - l. For enrollee/members with normal baseline tests, it is recommended that HbA1c or FBS are repeated at 12 weeks after initiation of treatment; and annually thereafter.
4. Monitoring
- a. HEDIS measure diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications to monitor compliance with lab draws will be run quarterly.
 - b. Treatment chart audits to validate labs ordered, weights and BMI done as recommended in clinical guidelines.
 - c. Clinicians should Document changes to target symptoms
 - d. Lack of significant response to treatment should result in an adjustment to treatment.

Clinical guidelines based on the following articles:

1. American Heart Association article, "Symptoms and Diagnosis of Metabolic Syndrome," September 15, 2016.
2. American Diabetes Association article, "Metabolic Screening after the American Diabetes Association's Consensus Statement on Antipsychotic Drugs and Diabetes," June 2009.
3. International Journal of Endocrinology article, "An Overview of Diabetes Management in Schizophrenia Patients: Office Based Strategies for Primary Care Practitioners and Endocrinologists,"

The Patient Health Questionnaire (PHQ-9) - Overview

The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression:

- The PHQ-9 incorporates DSM-IV depression diagnostic criteria with other leading major depressive symptoms into a brief self-report tool.
- The tool rates the frequency of the symptoms which factors into the scoring severity index.
- Question 9 on the PHQ-9 screens for the presence and duration of suicide ideation.
- A follow up, non-scored question on the PHQ-9 screens and assigns weight to the degree to which depressive problems have affected the patient's level of function.

Clinical Utility

The PHQ-9 is brief and useful in clinical practice. The PHQ-9 is completed by the patient in minutes and is rapidly scored by the clinician. The PHQ-9 can also be administered repeatedly, which can reflect improvement or worsening of depression in response to treatment.

Scoring

See PHQ-9 Scoring on next page.

Psychometric Properties

- The diagnostic validity of the PHQ-9 was established in studies involving 8 primary care and 7 obstetrical clinics.
- PHQ scores ≥ 10 had a sensitivity of 88% and a specificity of 88% for major depression.
- PHQ-9 scores of 5, 10, 15, and 20 represents mild, moderate, moderately severe and severe depression.¹

1. Kroenke K, Spitzer R, Williams W. The PHQ-9: Validity of a brief depression severity measure. *JGIM*, 2001, 16:606-616

The Patient Health Questionnaire (PHQ-9) Scoring

Use of the PHQ-9 to Make a Tentative Depression Diagnosis:

The clinician should rule out physical causes of depression, normal bereavement and a history of a manic/hypomanic episode

Step 1: Questions 1 and 2

Need one or both of the first two questions endorsed as a "2" or a "3"
(2 = "More than half the days" or 3 = "Nearly every day")

Step 2: Questions 1 through 9

Need a total of five or more boxes endorsed within the shaded area of the form to arrive at the total symptom count. (Questions 1-8 must be endorsed as a "2" or a "3"; Question 9 must be endorsed as "1" a "2" or a "3")

Step 3: Question 10

This question must be endorsed as "Somewhat difficult" or "Very difficult" or "Extremely difficult"

Use of the PHQ-9 for Treatment Selection and Monitoring

Step 1

A depression diagnosis that warrants treatment or a treatment change, needs at least one of the first two questions endorsed as positive ("more than half the days" or "nearly every day") in the past two weeks. In addition, the tenth question, about difficulty at work or home or getting along with others should be answered at least "somewhat difficult"

Step 2

Add the total points for each of the columns 2-4 separately
(Column 1 = Several days; Column 2 = More than half the days; Column 3 = Nearly every day. Add the totals for each of the three columns together. This is the Total Score
The Total Score = the Severity Score

Step 3

Review the Severity Score using the following TABLE.

PHQ-9 Score	Provisional Diagnosis	Treatment Recommendation <i>Patient Preferences should be considered</i>
5-9	Minimal Symptoms*	Support, educate to call if worse, return in one month
10-14	Minor depression ++ Dysthymia* Major Depression, mild	Support, watchful waiting Antidepressant or psychotherapy Antidepressant or psychotherapy
15-19	Major depression, moderately severe	Antidepressant or psychotherapy
>20	Major Depression, severe	Antidepressant and psychotherapy (especially if not improved on monotherapy)

* If symptoms present \geq two years, then probable chronic depression which warrants antidepressants or psychotherapy (ask "In the past 2 years have you felt depressed or sad most days, even if you felt okay sometimes?")

++ If symptoms present \geq one month or severe functional impairment, consider active treatment

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals _____ + _____ + _____

Add Totals Together _____

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult