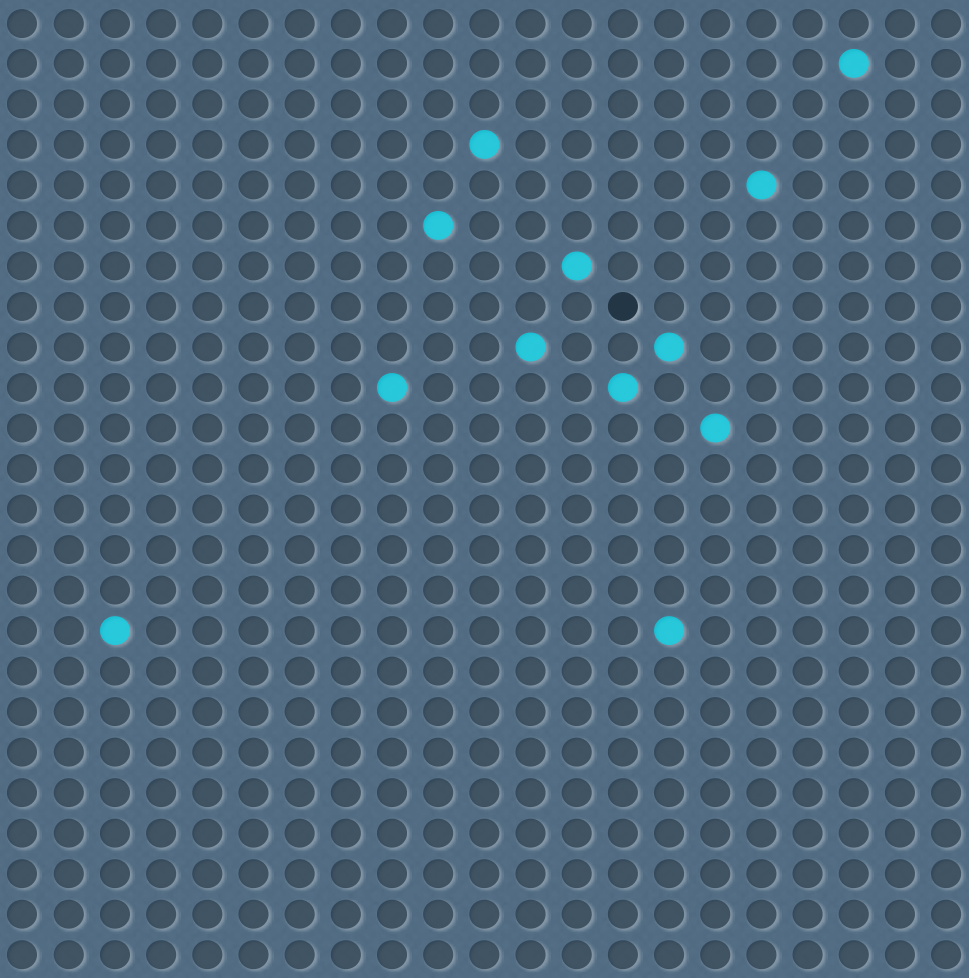
MASTER ABA

WHERE THE STUDENT BECOMES THE MASTER



Medical Necessity Criteria

WHAT YOU NEED TO KNOW

WHAT MAKES **ABA** MEDICALLY NECESSARY?

Medical necessity does not sound glamorous, fun or exciting but it is critical to billing for ABA services. Ensure that your plans and services meet medical necessity by understanding the requirements of each payer you work with. Each insurance company provides different criteria but there are some criteria common to most. Following these guidelines smooths the approval process and establishes a positive relationship with the payer.

You must understand the perspective of the payer to understand medical necessity. They seek to obtain the most efficient service that is likely to be effective for the client. As ABA professionals, we are biased toward believing that ABA is the best option for most individuals looking for services. Although that might be true in many cases, we also must recognize that ABA is a service associated with a comparatively astronomical cost.

When less expensive alternatives such as speech therapy or services at school may produce adequate results, the insurance company prioritizes those services. It becomes the responsibility of the ABA professional to justify the expense of ABA services.

Typically, insurance companies have strict guidelines for accessing ABA that include:

- Diagnosis
- Referral
- Deficits and/or behaviors related to diagnosis
- Parent or caregiver participation
- Demonstration of progress for ongoing treatment

Most insurance companies authorize services for 3-6 months and require you to continually justify that the service remains medically necessary. Generally, you must also describe your plan for generalization and discharge as ABA is intended to be a short-term intensive service.

Admission Criteria	Beacon	Tufts	New Directions	Aetna
Autism diagnosis	✓		✓	✓
Service consistent with DSM diagnosis			✓	
Service is least restrictive and most clinically appropriate			✓	
Required for reasons other than convenience			✓	
Not more costly than other treatments likely to be as effective			✓	
Diagnosis provided by a licensed practitioner through a comprehensive diagnostic assessment		✓	✓	
Behaviors or deficits related to diagnosis	✓	✓	✓	✓
Able to remain in home and participate in services	✓		✓	
ABA expected to be effective	✓		✓	
Parent or caregiver willing to participate in treatment			✓	✓
Client not receiving other ABA services	✓		✓	
Referral from diagnosing physician		✓	✓	
Treatment plan includes specific information including measurable goals				✓
Involvement by school or early intervention				✓
Specific requirements for supervision				✓

IDENTIFYING **ADMISSION** CRITERIA

Each insurance company provides guidelines for meeting medical necessity criteria at admission. These guidelines can usually be found on the company's website but if you have trouble finding them, they will be more than happy to email you a copy if you call.

Admission criteria typically revolves around documentation of the presenting problems. You base your determination of medical necessity on a review of reports from parents and medical and/or school personnel as well as your own observations.

Typically, the client must have a diagnosis (often of ASD) and many payers specify how that diagnosis was achieved. The rationale for this is based in the research as most research revolves around the application with individuals with autism.

Often the presenting deficits must be associated with the diagnosis that makes them eligible for treatment. This means that an individual with an autism diagnosis who seeks ABA services to address anxiety would not qualify for the service because anxiety is not a core deficit associated with autism.

Insurance companies may also specify the information that must be included in your initial assessment and treatment plan. This could include specific measurable goals, strategies for generalization, and a plan for discharge, among other requirements.

Even though each insurance company has a unique set of criteria, you don't need a different template for each one. Choose the company with the most stringent guidelines and develop a template that meets their criteria. An insurance company will not reject a treatment plan that provides too much information.

Typically, the initial request for treatment is the easiest to obtain as long as the diagnosis (and the means of obtaining the diagnosis) aligns with the payer's requirements. If you keep the payer's perspective in mind when generating your treatment plan, you have a higher likelihood of approval.

Continued Stay Criteria	Beacon	Tufts	New Directions	Aetna
Meets all admission criteria	✓	✓	✓	✓
No other level of care will meet client's needs	✓			
Reasonable to assume client will benefit from continuing ABA		✓		
Treatment will improve functioning to reduce the need for a high level of care	✓		✓	
Adequate progress is represented in graphs, session notes, progress notes, etc. and/or behavior plan altered to improve outcomes	✓	✓	✓	✓
Medication, if appropriate, has been ruled out	✓			
Parent or caregiver continues to participate in training and progress has been demonstrated	✓	✓	✓	
Ongoing planning for discharge seeks to reduce the level of care client requires	✓	✓	✓	
Service not being provided elsewhere (i.e. school)		✓	✓	
Adaptive behavior assessment required annually or skills assessment every 6 months			✓	✓
Level of impairment in line with hours requested				✓

IDENTIFYING **CONTINUED STAY** CRITERIA

Continued stay criteria are often similar in nature to the admission criteria; however, you must document progress to previously stated goals and present graphs depicting that progress. If adequate progress hasn't been made, you must identify factors impacting success along with your actions to address those factors. This should include an updated FBA and alterations to the BIP.

With continued stay requests, you must document a rationale for continuing services rather than discharging the client. The client must continue to meet the criteria for admission along with many other factors.

Most payers require documentation of parent or caregiver involvement to support generalization. This is to ensure that ABA services remain time-limited. This should not be considered a life-long service and the expectation is that parents and caregivers assume the responsibility of implementing intervention.

Although you are looking to continue with ABA services, you must also describe your criteria for discharge at this stage (some payers provide specific discharge criteria). It's generally insufficient to say that the client will be discharged when he or she performs at a level comparable to his or her peers. You should identify the specific milestones for each client that signify adequate progress for discharge.

Again, keep the perspective of the payer in mind. You should include information about ABA being the most cost-efficient option for treatment that is likely to be effective. Include information about how continuing ABA services will:

- Reduce the burden of care
- Improve independent functioning
- Reduce the need for long-term, more intensive treatment

Addressing these areas in your documentation allows the payer to see that you are working with them as a team to best meet the needs of the client.

Discharge Criteria	Beacon	Tufts	New Directions	Aetna
No longer meets admission criteria	✓	✓		✓
Initial goals have been met	✓			
Parent or guardian withdrew consent for treatment	✓			
Client, parent or caregiver not participating in treatment	✓			
Medication, if appropriate, has been ruled out	✓			
Client not making adequate progress	✓	✓		
Client's support system agrees with discharge	✓			
Less intensive services have become appropriate		✓		
Treatment is making symptoms worse		✓		
The target behaviors have diminished and don't impact functioning or occur in the natural environment				✓

IDENTIFYING **DISCHARGE** CRITERIA

Although many insurance companies list specific discharge criteria, some do not. These payers rely on your clinical judgement and the determination of medical necessity.

Almost universally, the client must continue to meet admission criteria to continue with services so naturally, if the client no longer meets admission criteria, it's time to discharge. This might mean the client no longer demonstrates behaviors associated with the diagnosis or that the client could benefit from a less intensive service.

If the client has achieved all the goals identified in the treatment plan or the client no longer displays the target behaviors in the natural environment, it's time to celebrate… and discharge. Don't fall into the trap of continually identifying new goals to address. When the client achieves his or her goals, discharge. The client can always return to services if the need arises again.

Discharge should also occur if ABA treatment does not result in the expected improvements or makes symptoms worse. There are many reasons why this could occur and does not reflect badly on you as a practitioner. The client's behaviors or deficits might be outside your scope of competency or maybe your program's environment is not the right fit for the client. When you discharge for these reasons, make sure you make every attempt to connect the client with more appropriate alternatives.

If the client, parent or caregiver stops participating in treatment, you should consider discharge, after making a concerted effort to engage them. Lack of participation that impacts treatment or generalization should be addressed and without a notable improvement, this should lead to discharge. It's possible that the family is experiencing emotional or financial difficulties that make services impractical or difficult. Whatever the reason, if now isn't the right time for services, plan to discharge. They can come back for services when they are ready to commit to participating in them.

Letting go of a service that has had monumental impact on their lives and their child's success can be hard.

PREPARING PARENTS FOR DISCHARGE

The discussion around discharge should begin at intake. Many parents feel blindsided when ABA professionals bring up discharge years into service. They are likely unaware of the requirements for medical necessity and may have thought that ABA services would be an ongoing support for them.

Each request for authorization for continued stay presents another opportunity to discuss discharge. Share with parents the criteria you identified in your plan. Openly discuss the rationale for medical necessity criteria.

Frequent conversations about the criteria for discharge help parents prepare for the inevitability of it. When their child meets criteria for discharge, help them celebrate the victory that it truly is.

Assure parents that you plan to titrate (gradually reduce) ABA services to ensure the client remains stable with a reduction in the service. Any significant increase in the client's symptoms could lead to a return to more intensive services. Abruptly terminating services may lead to a resurgence in the behaviors or deficits that originally brought the parent in to seek services. Whenever possible, plan for a gradual reduction. This helps parents also prepare for the loss of support, especially if the client has been receiving ABA for an extended period of time.

If parents continue to struggle with a reduction in services, offer to increase parent training and/or move to a parent training only model of service delivery. It can feel overwhelming to suddenly find yourself in the position of implementing interventions. This transfer of responsibility should happen gradually as direct service hours are thinned.

Work with parents to identify a plan for them to access help, support or additional resources if needed. When should they come back if they feel they need help? Be clear that you will be available to them if they need you in the future.