Appendix A: Model Plan Language for Medicaid Plans

Note: The proposed plan language is meant to be modifiable to meet the needs of a variety of case management structures.

Diagnostic evaluations

In order to receive services under this section, a member must be diagnosed with an autism spectrum disorder (ASD), Pervasive Developmental Disorder – Not Otherwise Specified (PDD-NOS), or with developmental concerns indicating a possible diagnosis of Autism Spectrum Disorder or PDD-NOS,[1] by:

- A licensed physician (MD or DO)
- A licensed psychologist with a doctoral-level degree (PhD or PsyD); or
- Another licensed professional authorized by state law to diagnose developmental disabilities.

The diagnosis must be based on a face-to-face evaluation using a clinically recognized, validated tool.

Diagnostic evaluation services are covered when they are performed by a licensed physician, a licensed clinical psychologist with a doctoral-level or masters-level degree, or a licensed clinical social worker. Diagnostic consultations from other health care professionals, such as a speech-language pathologist, occupational therapist, are covered when requested by a diagnosing physician or clinical psychologist.

No prior approval is needed for a diagnostic evaluation. The case management team may, however, request the results of a diagnostic evaluation as a prerequisite to prior approval of services requiring such prior approval under this section.

Types of care available to individuals with a primary diagnosis of ASD

Habilitative Services

Habilitative services are services designed to mitigate difficulties in acquiring skills that the covered individual has not yet attained and that are necessary for activities of daily living. Such activities include, but are not limited to, walking, speaking, communicating, feeding or dressing oneself, maintaining hygiene, learning in school (in the case of a child), or working (in the case of an adult).

Habilitative services may include, but are not limited to:

- Speech therapy to teach a covered individual how to talk or understand spoken information;
- Communication interventions designed to teach a covered individual how to communicate including use of some means other than speech, such as through typing, signing, pointing, or using a picture board;
- Physical therapy to teach a covered individual how to roll over, sit, walk, or acquire other motor skills;
- Occupational therapy to teach a covered individual how to increase participation in activities of daily living; increase participation in leisure/play, work, education, and relationships; balance while standing, sitting or walking; or assist with

1 Some diagnosticians are reluctant to diagnose ASD before a certain age, but nevertheless are able to identify concrete developmental concerns that may be addressed through habilitative or other similar interventions.

ability to meet behavioral, environmental, contextual, performance, or other activity demands in educational, work, or other community settings consistent with the individual's goals; and

- Social communication or developmental interventions to assist with emotional or behavioral regulation.

Note on services available through other payers.

In some cases, habilitative services may be available through other payers, such as:

- A public school, as required by the Individuals with Disabilities Education Act; or
- A public vocational rehabilitation program.

Habilitative services may be eligible for coverage when medically necessary, even when another payer is responsible for providing other habilitative services in the same category. For example, a child receiving occupational therapy at school for the purposes of learning to write may still be entitled to occupational therapy at home for the purposes of meeting other developmental goals, provided that they are not duplicative of services that are already being provided through another payment source. The case management team may, however, request records relating to services provided through other payers, or may request consultation with the providers of these services, in order to ensure efficient coordination of services.

Mental Health Services

Medically necessary mental health services, including individual and group psychotherapy, may be available for a primary diagnosis of Autism Spectrum Disorder or a dual diagnosis of Autism Spectrum Disorder and another diagnosis listed in the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM). See "Medical Necessity Criteria" for further information on when mental health services may be considered medically necessary.

Pre-authorization requirements

[Health plans may wish to impose pre-authorization requirments for ASD-related services to the same extent that they require pre-authorization of similar services delivered to people with other diagnoses, at the same intensity. For example, if health plans require pre-authorization of occupational therapy for injuries, they may also require pre-authorization of occupational therapy for ASD. Pre-authorization may be a valuable mechanism for quality control in addition to utilization control.]

The following text is included as an example of pre-authorization language for a plan that typically requires similar pre-authorization of habilitative or rehabilitative interventions.

Habilitative interventions require authorization prior to the start of treatment and at six-month intervals thereafter. Examples of habilitative interventions include:

- Developmental interventions such as DIR/Floortime;
- Social communication interventions; or
- Occupational, physical, or speech therapy.

The first request for pre-authorization by the prescribing provider should include:

- The date of the diagnostic evaluation;
- The name, contact information, and credentials of the diagnosing provider;
- The name of the tool or assessment used in the evaluation;
- A description of the results of the diagnostic evaluation;

- A description of the results of any non-diagnostic evaluations for the purposes of identifying service needs;
- A clinical diagnosis or description of developmental concerns indicating a need for intervention; and
- Where an intervention targets behavior that may be caused or complicated by an underlying medical condition, documentation of investigation into potential medical causes or complicating factors.

Periodic Review

The case management team may request to review an intervention plan subject to pre-authorization:

- Every six months, for a plan for which the majority of service hours are delivered by a para-professional without a degree from an accredited program and not licensed by the state;
- Every year, for a plan under which the majority of service hours are delivered by a professional with a degree from an accredited program, and licensed by the state;
- Whenever the plan is significantly altered, including the addition of a new goal; or
- When the case management team determines that review is necessary in light of other developments in an individual's health or plan of care, such as a new diagnosis or commencement of an intervention or treatment program that may affect the individual's participation in the existing plan.

If it appears to the case management team that an intervention has not produced measurable results in the time period anticipated, the case management team may recommend, as a condition of continued coverage, a re-assessment of the plan. The re-assessment may include proposals for alternative interventions, progress measurement methods, standardized evaluations, or goals. Alternatively, the re-assessment may lead to a referral for further evaluation, such as an evaluation to rule out potential medical barriers to achievement of the goal.

Medical necessity criteria

Medically necessary services, in the context of Autism Spectrum Disorder, are those that are:

1. Intended to:
    a. detect or diagnose Autism Spectrum Disorder (ASD);
    b. improve an individual's ability to acquire or retain skills necessary for activities of daily living, such as walking, speaking, communicating, feeding or dressing oneself, maintaining hygiene, learning and participation in school (in the case of a child), or working (in the case of an adult);
    c. prevent, diagnose, correct, cure, alleviate or preclude deterioration of secondary conditions that threaten life, cause pain or suffering, or result in illness or infirmity; or
    d. Enable the individual to access the benefits of community living and exercise autonomy.
2. Based on an individualized assessment of, and consistent with, an individual's strengths, skills, situation, goals, characteristics, preferences and priorities, and not primarily intended for the convenience of the recipient, caretaker, or provider or elimination of the appearance of disability.
3. Not in excess of or inconsistent with the individual's needs, and generally accepted as safe and unlikely to cause significant adverse effects, including clinically significant distress or trauma.
4. Consistent with accepted standard clinical practices generally recognized by mental health or substance use care professionals or publications.

5. Consistent with the expertise and training of the provider.

6. Provided in the most integrated, inclusive and least restrictive setting appropriate to the individual's needs and goals, and at a level of intensity that balances efficacy with the individual's need for routine, rest, sleep, and opportunities to participate meaningfully in school, work, and other aspects of daily life.

Secondary conditions that threaten life, cause pain or suffering, or result in illness or infirmity

There is no accepted intervention to prevent or cure Autism Spectrum Disorder (ASD). Nevertheless, individuals with a diagnosis of ASD may need interventions to prevent or ameliorate secondary challenges associated with ASD. Examples include:

- Anxiety or distress associated with overwhelming or unpredictable stimuli;
- Special nutritional needs associated with selective eating;
- Need for adaptive or sensory-friendly strategies for managing other health conditions;
- Need for specialized safety instructions or health education necessary to prevent injury or illness;
- Need for sensory-friendly approaches to delivery of health care in clinical environments; or
- Occupational therapy to develop sensory, cognitive, emotional regulation, or communication interventions intended to reduce impulses toward behaviors that may injure self or others.

Individualized Assessment

Individualized Goals

Interventions must be focused on an individualized assessment of an individual's skills, situation, goals, and characteristics. Examples may include:

- Gaining independence in activities of daily living;
- Improving communication skills;
- Transitioning to adulthood and independence, including employment, higher education and community integration;
- Developing emotional and sensory self-regulation strategies and reducing anxiety;
- Developing cognitive skills; or
- Amelioration of health consequences secondary to ASD diagnosis, such as selective eating.

Interventions aimed at reducing the appearance of disability – such as efforts to increase eye contact or reduce self-stimulatory behavior – are generally considered not to be medically necessary unless they also implicate an individual's mental health, physical health, or ability to function independently and communicate.

Necessity of Ruling out Medical or Other Causes

The case management team may, when consistent with clinical best practices, require that the individualized assessment include an assessment designed to rule out potential medical or other psychiatric causes of the concern to be targeted by the intervention. For example, it may be necessary to rule out medical causes of sudden changes in behavior – especially in a child or an adult with communication barriers – before attempting to address them through behavioral or mental health interventions.

Services that are Unsafe or Inconsistent with Individual Needs

Interventions that are inconsistent with individual needs or safety will not be covered. Examples include, but are not limited to:

- Biomedical interventions inconsistent with accepted clinical practice, such as chelation, "mineral" therapies, or hyperbaric oxygen therapy; or
- Interventions that use aversive or unpleasant stimuli to modify behavior, including skin shocks, unpleasant odors, deprivation of food, or seclusion and restraint.

Interventions may also be inconsistent with an individual need. For example, an intervention that uses sugar-containing food as a behavioral reinforcement may be inappropriate for a child with diabetes.

Accepted Standards of Clinical Practice

Consistency with accepted standard clinical practice shall be assessed with respect to the individual care plan – including the specific goal(s) listed in the plans – and not with respect to the clinician's use of a published "brand name." For example, "branded" interventions such as TEACCH, Floortime, and SCERTS may include antecedent-focused, joint attention, social communication or developmental interventions[2] that are consistent with standard clinical practice for a particular individual. Similarly, although targeted behavioral interventions may be consistent with standard clinical practice in order to achieve specific behavioral goals, the fact that an intervention is advertised or branded as behavioral or "applied behavioral" does not necessarily imply that it is consistent with standard clinical practice for a particular goal.

The case management team may request records of services provided in order to ensure consistency of services with the plan of care. In plans under which the majority of service hours are provided by paraprofessionals supervised by a licensed clinical provider, the case management team may specifically request records documenting, in detail, faithful adherence to the plan of care and adequate supervision of paraprofessionals.

Qualifications of Providers

Interventions should be consistent with the expertise, licensing, or other qualifications of the provider. For example, interventions for the purposes of meeting occupational goals should be provided by a licensed occupational therapy practitioner, such as an occupational therapist or an occupational therapy assistant under the supervision of an occupational therapist. Likewise, speech-related interventions should be delivered by a qualified speech-language pathologist or psychologist.

In some cases, an intervention may require consultation with individuals in related areas of expertise. For example, an individual with significant motor impairments may be in need of an alternative form of communication, such as typing or picture-based communication system. Implementing the alternative communication strategy may require input or assistive technology support from an occupational therapist.

Settings requirements

As articulated in *Olmstead v. L.C.*, services funded through this plan must comply with the integration mandate in Title II of the Americans with Disabilities Act (ADA). Interventions must be delivered in a manner that maximizes an individual's ability to remain in non-restrictive, integrated settings. For example, intensive interventions should be delivered, to the maximum extent possible, in the individual's natural environment and at a time that maximizes the individual's ability to participate in school, work, and family life.

Interventions should not be at a level of intensity that interferes with an individual's other needs, including educational, vocational, family, or other health care needs.

Interventions should be scheduled at a time and place where the individual is able to benefit from them. Interventions that require active participation and attention from the individual should generally be scheduled at a time when the individual is likely to be able to actively engage in them, and not immediately after a long school or work day. Interventions designed to teach daily skills should, to the

2 http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Downloads/Autism-Spectrum-Disorders.pdf

extent possible, be delivered in a setting that is conducive to generalization of those skills – ideally, the same setting and time in which those skills are to be used. Case management teams will require pre-authorization of intensive services provided outside of a natural community setting.

Clinical or office settings may be appropriate for less intensive interventions, such as individual or family counseling, neuropsychological testing, or group therapy.

Licensing requirements

Coverage of services pursuant to this section is limited to:

- Mental health providers who are currently licensed in the state in which services are delivered, and for whom the service provided is within their scope of practice;
- A licensed physician licensed as an MD or DO in the state in which services are delivered;
- A licensed occupational therapist, physical therapist, or speech-language pathologist, operating within the scope of practice, and pursuant to a referral from a licensed mental health provider, psychiatrist, or physician;
- A Board Certified Behavior Analyst, or a Board Certified Assistant Behavior Analyst (BCaBA) with no current license in the categories listed above, must be supervised by a licensed psychologist, psychiatrist or developmental pediatrician. The supervising provider must submit both the request for authorization and the claim for payment.
- An occupational therapy assistant, physical therapy assistant, or speech-language pathology assistant, supervised in accordance with state licensure laws and Medicaid requirements.