Southwest Michigan Behavioral Health

Section: **Clinical Practices**	Procedure Name: **Applied Behavior Analysis (ABA)**	Procedure #: **P12.08.01**
Overarching Policy: **12.08 Autism Services**		
Owner: **Director of Clinical Quality**	Reviewed By: **Alena Lacey** **Sarah Ameter**	Total Pages: **11**
Required By: ☐ **BBA** ☒ **MDHHS** ☐ **NCQA** ☐ **Other (please specify):** _____	Final Approval By: *Alena Lacey* *Sarah Ameter*	Date Approved: Feb 28, 2022
Application: ☒ **SWMBH Staff/Ops** ☒ **Participant CMHSPs** ☐ **SUD Providers** ☒ **MH/IDD Providers** ☐ **Other (please specify):** _____	Line of Business: ☒ **Medicaid** ☒ **Healthy Michigan** ☐ **SUD Block Grant** ☐ **SUD Medicaid** ☐ **MI Health Link** ☐ **Other (please specify):**	Effective Date: **6/9/14**

Purpose: To identify the required and necessary steps for authorization, utilization and quality management of the Medicaid Autism benefit.

Scope: Staff of participant Community Mental Health Service Providers (CMHSP) and provider agencies who are responsible for assessing, planning, coordinating and providing services for youth and families.

Definitions:

A. **Behavioral Assessment –** Use of validated instrument(s), along with direct observational assessment, observation, record review, data collection, and analysis as applicable, by a qualified provider. Current level of functioning of the child using a validated data collection method must be included. Examples of behavior assessments include functional analysis and functional behavior assessments. 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).

B. **Comprehensive Diagnostic Evaluation** - The determination of an autism diagnosis by a Qualified Licensed Practitioner, which is accomplished by direct observation and utilizing the Autism Diagnostic Observation Schedule-Second Edition (ADOS-2), and by administering a comprehensive clinical interview including a developmental symptom history (medical, behavioral, and social history) such as

the Autism Diagnostic Interview-Revised (ADI-R) or clinical equivalent. In addition, a qualified licensed practitioner will rate symptom severity with the Developmental Disabilities Children's Global Assessment Scale (DD-CGAS). Other tools should be used if the clinician feels it is necessary 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).

Procedure:

A. **Screening and Referral**: Referrals for ABA services may be made directly by a customer's parent/guardian, an adult customer, or a Primary Care Physician. If received from a Primary Care, the CMHSP will document the original request and follow up with the parent/guardian or adult customer to schedule screening and intake. CMHSP staff will document all attempts to reach the parent/guardian or adult customer (minimum of 3 contact attempts). If the parent/guardian or adult customer is unable to be reached, the CMHSP will document all attempts to reach them and close out the referral if there is no response from the parent/guardian within 14 calendar days. If the CMHSP reaches the parent/guardian or adult customer and they decline to schedule screening, the CMHSP will document that they are choosing not to follow up with the referral.

Referrals may also be sent by other offices such as Child Protective Services, Foster Care workers, etc. If referrals are made by these external sources, the request for service is considered received once the CMHSP confirms that the parent/guardian or adult customer wishes to make a service request. The CMHSP will ask the external source to have the parent/guardian or adult customer call the CMHSP to confirm that they are making a request for services. The call or contact will be documented in the CMHSP record. If the parent/guardian or adult customer does not contact the CMHSP within 14 calendar days, the referral will be closed out. If the parent/guardian or adult customer declines to schedule screening and intake, the CMHSP will document that they are choosing not to follow up with the referral.

If a request is made after business hours by Primary Care Physician, parent/guardian, or adult customer by voicemail, fax, mail, or email, the request for service will be considered received once the CMHSP receives the request (the next business day). For customers already open to services, the request will be considered received on the date that the parent/guardian or adult customer makes the request of the primary case holder. This request will be documented in the CMHSP record.

CMHSP staff will educate the parent/guardian or adult customer about the process for accessing ABA services. The parent/guardian or adult customer will be informed that the first step is to request a Comprehensive Diagnostic Evaluation.

When a participant CMHSP receives a request for ABA services for an individual who is 21-years-old or younger, a trained screener (per Medicaid Provider Manual requirements) will have 14 calendar days to use a validated and standardized screening tool (e.g., Modified Checklist for Autism in Toddlers (M-CHAT), Social Communication Questionnaire (SCQ), Childhood Autism Rating Scale (CARS), based on relevance to the customer), to assess the likelihood of an autism or autism spectrum disorder (ASD) diagnosis.

If a pediatrician or other qualifying provider has completed an ASD screening for the individual within the past 3 months, this screening may be used for Comprehensive Diagnostic Evaluation referral purposes.

If the standardized screening tools cannot be made within the prescribed 14-day timeframe, the CMHSP may determine the need for an extension of the timeframe. The extension may not exceed 14 additional days from the original due date. The CMHSP must be able to justify that the extension is in the customer's best interest and the need for additional information. CMHSP staff will make reasonable efforts to provide the parent/guardian or adult customer with prompt oral notice of the delay and will mail a letter within 2 days, giving the reason for the extension and the right to file a grievance if they disagree with the extension. If extended, a decision must be made and issued no later than 28 calendar days from the original request date.

If the standardized screening tool is not completed timely, the CMHSP must issue an Adverse Benefit Determination (ABD) no later than 14 calendar days for standard decision or 28 calendar days if an extension was taken, notifying the customer of this and their appeal rights.

If the screening tool does not support the need for a Comprehensive Diagnostic Evaluation, then an Adverse Benefit Determination (ABD) will be provided by the CMHSP, denying the Comprehensive Diagnostic Evaluation (ADOS-2, ADI-R, etc.). The CMHSP will provide referrals to other services that may benefit the family, which may include an intake for other CMHSP services. If the screening tool supports the need for a Comprehensive Diagnostic Evaluation, a referral will be made and authorizations entered for a full Comprehensive Diagnostic Evaluation, to provide diagnosis and treatment recommendations for suspected Autism or ASD.

Families presenting to Southwest Michigan Behavioral Health (SWMBH) will be referred to the Participant CMHSP for the county in which they reside for screening.

B. **Intake**: Participant CMHSP will complete an intake and case opening process, including full primary assessment of needs and initial Individualized Plan of Service (IPOS), which will include the referral for the completion of the Comprehensive Diagnostic Evaluation and any other relevant needs.

C. **Comprehensive Diagnostic Evaluation:** Participant CMHSP or other appropriately credentialed and contracted Qualified Licensed Practitioner with prior authorization will perform a Comprehensive

Diagnostic Evaluation to assess for suspected Autism or ASD and develop treatment recommendations as necessary. The Comprehensive Diagnostic Evaluation will be completed within 14 calendar days from the date the authorization is entered in the CMHSP record.

If the Comprehensive Diagnostic Evaluation cannot be completed within the prescribed 14-day timeframe, the CMHSP may determine the need for an extension of the timeframe. The extension may not exceed 14 additional days from the original due date. The CMHSP must be able to justify that the extension is in the customer's best interest and the need for additional information. CMHSP staff will make reasonable efforts to provide the parent/guardian or adult customer with prompt oral notice of the delay and will mail a letter within 2 days, giving the reason for the extension and the right to file a grievance if they disagree with the extension. If extended, a decision must be made and issued no later than 28 calendar days from the date the authorization was entered in the CMHSP record.

The Comprehensive Diagnostic Evaluation must be completed by a Qualified Licensed Practitioner as described in section 18.3 of the Medicaid Provider Manual.

The Comprehensive Diagnostic Evaluation shall include:

1. Administration and documentation of the Autism Diagnostic Observation Schedule (ADOS-2),
2. A clinical interview, including a developmental symptom history (medical, behavioral, and social history) utilizing a tool such as the Autism Diagnostic Interview, Revised (ADI-R) or clinical equivalent,
3. A rating of symptom severity with the most current Michigan Department of Health and Human Services (MDHHS) required scale (e.g. Developmental Disabilities-Children's Global Assessment Scale, Clinical Global Impression Severity Scale),
4. Consultation with other providers and/or administration of other clinical assessments, as needed to determine a diagnosis, rule out medical factors, and develop service recommendations,
5. A comprehensive summary of relevant findings and treatment recommendations.

If a customer seeking ABA services provides a complete Comprehensive Diagnostic Evaluation from a qualified provider that took place within the past year, and no significant changes have occurred or diagnostic questions remain, the CMSHP will accept this report as the Comprehensive Diagnostic Evaluation rather than complete another full assessment/evaluation battery. A new Comprehensive Diagnostic Assessment will be required within 365 days of the date the accepted evaluation was completed.

To qualify for the benefit, the customer must meet medical necessity criteria for ABA services, as defined in section 18.4 of the Medicaid Provider Manual, and the service requirements listed in section 18.5. of the Medicaid Provider Manual. A diagnosis for Autism or ASD alone is not sufficient to demonstrate medical necessity for ABA services.

Following the Comprehensive Diagnostic Evaluation, the CMHSP completes the ABA Services Referral Form indicating the customer's eligibility or ineligibility for services per the qualified licensed practitioner's evaluation and recommendations. This form is submitted only via secure email to SWMBH's Clinical Quality Specialist. A faxed referral form may only be sent in special circumstances discussed in advance with SWMBH's Clinical Quality Specialist. The clinical quality specialist will then use the data from the evaluation to update the customer's record on the WSA and submit it to MDHHS for approval in the benefit.

A new Comprehensive Diagnostic Evaluation must be completed every 3 years and forwarded to SWMBH's Clinical Quality Specialist via secure email to verify continuing eligibility for services. This is referred to as a renewal of the benefit later in this policy.

If the Comprehensive Diagnostic Evaluation is not completed timely, the CMHSP must issue an Adverse Benefit Determination (ABD) notifying the customer of this and their appeal rights. For new requests, the ABD would be issued no later than 14 calendar days from the date the authorization was entered in the system (28 calendar days if an extension was taken), for re-evaluations, before the 3 year expiration date.

D. **Enrollment:** When a complete SWMBH ABA Services Referral form is received indicating eligibility, the SWMBH Clinical Quality Specialist will verify the customer's eligibility for ABA services and will enter him/her into the WSA for enrollment into the ABA program. If eligibility status is not clear, the Clinical Quality Specialist will contact the CMHSP for additional information. SWMBH will receive notification of ABA Service enrollment from MDHHS through the WSA application and will contact the participant CMHSP who submitted the referral (or staff identified by the participant CMHSP for Autism referrals) to inform of eligibility status.

E. **Ineligibility**: If an individual is determined to be ineligible for ABA services *by the CMHSP* at any time, the CMHSP will issue the proper Adverse Benefit Notification to the customer (for adult customers with no guardian) or to the parent/guardian of the customer and informing them of their appeal rights. The SWMBH Clinical Quality Specialist must be notified so dis-enrollment can take place in the Michigan Department of Health and Human Services (MDHHS) WSA.

If an individual is determined to be ineligible for ABA services *by SWMBH* at any time, SWMBH will issue the proper Adverse Benefit Notification to the customer and will inform the CMHSP.

F. **Requests to Postpone:** During the initial screening process (standardized screening tools, Comprehensive Diagnostic Evaluation), if the guardian/parent or adult customer requests an appointment date/time that is past the allowed timeframe for decision making, the CMHSP will document the request for an appointment outside of the (14 day) timeframe and the reason for the request in the CMHSP record.

If the request can be accommodated within 28 days of the original service/authorization request date, the CMHSP will extend the timeframe to the 28 days allowed and provide oral and written notification to the parent/guardian or adult customer per the authorization extension process. It will be documented that the extension was at the request of the parent/guardian or adult customer.

If the request to postpone is beyond 28 days from the initial service/authorization request, the CMHSP will document in the CMHSP record that the parent/guardian or adult customer has requested to postpone the appointment. If a treatment plan has not yet been completed, the CMHSP will note the ABA assessments in the "deferred needs" section of the treatment plan. If the treatment plan has already been completed and testing authorized, CMHSP will issue an Adverse Benefit Determination to delay the authorization based on the parent/guardian or adult customer's request.

G. **Dual Insurance:** If a family has both a third party/private insurance in addition to Medicaid, the CMHSP must adhere to the Medicaid coordination of benefits rules. If deemed eligible by the third party, the CMHSP must use the third party's assessment to complete the ABA Referral Sheet, denoting both insurances. SWMBH's Clinical Quality Specialist will upload the customer to the WSA and inactivate them as having "dual insurance." If a customer has both a third-party insurance and Medicaid but with no third-party coverage for ABA services, the CMHSP must secure a denial from the private insurance carrier before proceeding with the standard Medicaid process for enrolling a customer into the benefit.

H. **Behavioral Assessment:** After initial eligibility has been verified, participant CMHSP staff will arrange a Behavioral Assessment by an appropriately credentialed clinician, which will determine recommendations for the intensity of the ABA Service. Behavioral Assessments must use a validated instrument and can include direct observational assessment, observation, record review, data collection and analysis by a qualified provider as referenced by the Michigan Medicaid Manual section 18.12. The Behavioral Assessment will assess the current level of functioning of the customer. 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), Assessment of Functional Living Skills (AFLS), etc. These assessments must be completed a minimum of once every six months; however, these may be done more often based on needs/status of the customer.

I. **Individual Plan of Service (IPOS)**: Through a person-centered planning process, the participant CMHSP primary clinician, along with the planning team, will create an IPOS or addendum to the initial IPOS based on recommendations from the Behavioral Assessment, to facilitate the child's goal attainment. IPOS goals and supports may serve to reinforce skills or lessons taught in school, therapy, or other non-CMHSP provider settings, but are not intended to supplant services provided in school or other settings, or to be provided when the child would typically be in school but for the parent's/guardian's choice to home-school their child. Each child's IPOS must document that these services do not include

special education and related services defined in the Individuals with Disabilities Education Act (IDEA) that are available to the child through a local education agency.

The IPOS shall address the identified needs of the customer, including risk factors and parent training needs (which should be done at minimum quarterly). The IPOS will clearly identify the amount, scope, and duration of ABA services that are being requested for authorization, along with goals and specific objectives to achieve those objectives. The IPOS shall include specific targeted behaviors for improvement, along with measurable, achievable, and realistic goals for improvement and shall address other identified needs of the customer, including risk factors. The recommended service level and setting(s) will be included in the child's IPOS, with the planning team and the parent(s)/guardian(s) reviewing the IPOS at regular intervals (minimally every three months) and, if indicated, adjusting the service level and setting(s) to meet the child's changing needs. ABA Service Levels are defined below.

1. **Focused Behavioral Intervention**: Focused behavioral intervention is provided an average of 5-15 hours per week (actual hours needed are determined by the behavioral plan of care and interventions required).
2. **Comprehensive Behavioral Intervention**: Comprehensive behavioral intervention is provided an average of 16-25 hours per week (actual hours needed are determined by the behavioral plan of care and interventions required).

Only Adaptive Behavioral Treatment, Group Adaptive Behavioral Treatment and Exposure Adaptive Behavioral Treatment are counted towards the ABA service Levels. Family Training, Social Skills Group and Behavioral Identification Assessment are not. They must be denoted in the WSA or the upload form.

The initial IPOS shall be developed within 90 days of eligibility and will be uploaded to the WSA by the SWMBH staff member.

All Behavior Technicians working with a child shall be trained in his/her IPOS and any addenda prior to the delivery of direct ABA services. The attached IPOS Training Verification form may be used as proof of this training. Monitoring of this training will occur during site reviews.

J. **Authorizations:** ABA is prior authorized for a time period not to exceed 365 days via an IPOS. The total number of direct ABA hours being authorized will need to be based on both 1) medical necessity and 2) customer/families' availability. An IPOS is reviewed for customers receiving ABA at least quarterly (every three months); but can be reviewed as often as a customer/family chooses.
When prior-authorizing, Utilization Management (UM) staff will independently assess the medical necessity of the ABA services being requested (including amount, type, scope and duration).
If the services requested align with the individual's identified needs, treatment plan goals, and ability to benefit, then the medical necessity of the plan may be approved. Attachment L. ABA Authorization Review Form may be used to guide this process but is not required by SWMBH.

If medical necessity cannot be established, then the relevant services cannot be approved. Utilization Management reviewers who are not credentialed as BCBAs may not deny ABA services. If there is a potential need for a denial, then complete the BCBA consultation (see section J).

K. **BCBA Consultation for Denials:** Denials of ABA services shall be made by a BCBA. SWMBH has a BCBA available to CMHs for consultation for possible medical necessity denials or other ABA medical necessity consultation requests. If a CMHSP has a BCBA on staff within their organization, who is not involved with the case being reviewed, that person may complete the consultation/authorization decision process internally.

The Following Steps will be used for all medical necessity consultation with SWMBH BCBA:

1. CMHSP Utilization Management Staff will complete BCBA Consultation Form and send it alongside all gathered reports and plans to the SWMBH Clinical Quality Specialist within 7 calendar days of initial authorization request.
2. SWMBH will then provide contact information of Utilization Management staff and all relevant documents to contracted BCBA consultant for review, consultation, and medical necessity determinations.
3. BCBA consultant will review the information and make a final decision within 5 calendar days of request for consultation. Decisions of the BCBA consultant could include, but are not limited to:
   a. Authorizing a 1-month authorization to allow for modification of treatment plan to better match the requested authorization
   b. Approval of the initial authorization request based on additionally gathered information
   c. Denial of authorization based on medical necessity criteria.

If a partial approval/denial is the outcome of the medical necessity consultation, then SWMBH will be responsible for sending the Adverse Benefit Determination (ABD) to the consumer within the required timeframe. Upon receipt of the ABD, the customer will be allowed to appeal the authorization decision, at which time a second BCBA will be contacted to complete the review.

L. **MDHHS Requests:** MDHHS will issue a biannual Quality Performance Review to SWMBH to be disseminated to the individual CMHSPs. The CMHSP will provide timely responses and submit them to the Clinical Quality Specialist who will compile a regional report for MDHHS. SWMBH will identify due dates to meet the timeliness requirement.

M. **ABA Performance Metrics:** The Clinical Quality Specialist will send CMHSPs a detailed report each month on one or more of the metrics below. This report will include case-level data as it relates to the following performance metrics:

1. ABA services shall be provided within a plus or minus 25% variance of service hours authorized in the IPOS.
2. Face-to-face behavioral observation and direction will be performed by a BHT Supervisor at a minimum of 1 of every 10 hours of ABA services rendered to a customer.

3. Once a customer has been enrolled in the benefit, an IPOS that contains ABA services shall be created and uploaded to the WSA within 90 days.
4. Behavioral Assessments shall be completed minimally every six months.
5. An updated IPOS shall be created within 365 days of the previous IPOS.
6. Each family currently enrolled in ABA services is receiving at minimum one instance of Family Training per quarter.

The purpose of the Monthly Performance Reports is to provide data to inform CMHSPs of areas of strength and to assist in improving areas of poor performance. By the end of the month of each report's distribution, the CMHSP will provide timely case level responses documenting remedial actions that have been taken to rectify areas of non-compliance. If the response is not acceptable, or SWMBH sees continued performance problems, SMWBH may follow up with a request for additional information. If non-compliance trends persist, a formal corrective action plan will be requested.

N. **ABA Provider Reviews:** SWMBH will conduct a clinical and administrative review annually of the contracted ABA service providers and CMHSPs delivering ABA services within the region. Providers will be notified at least 30 days prior to a scheduled site visit with the review date and time. SWMBH may additionally review cases via unscheduled focused review of clinical documentation. Review elements are listed below.
   1. The SWMBH Primary and Clinical Providers Administrative Site Review Tool (see SWMBH Operational Policy 2.13) will be used to assess administrative functions.
   2. The SWMBH ABA Provider Clinical Quality Review Tool (Attachment) will be used to review a random sample of clinical records of ABA providers and CMHSPs delivering ABA services. The clinical sample will be supplied to the provider 5 days prior to the review. A minimum of 5% or 8 customers per provider (whichever is more), or 5 cases per site, shall be reviewed. Additionally, the SWMBH Clinical Quality Review tool shall be utilized annually with each CMHSP to assess clinical records.
   3. BCaBA, BCBA, BT, LLP/LP, QBHP, and QLP Provider Qualifications tools (Attachments) will be used to verify the credentials of ABA professionals and techs, minimally one of each professional type and three behavior techs, to be selected by SWMBH.

Once the review is completed, a corrective action plan (CAP) will be requested from the provider for follow up and corrections as necessary. This will be posted to the SWMBH Portal by the Clinical Quality Specialist for review by the CMHSPs in the SWMBH Network. Responses, in addition to corrections, shall be submitted to SWMBH for approval within 45 days after the provider receives their CAP.

References: Michigan Medicaid Manual: Section 18- Behavioral Health Treatment/Applied Behavior Analysis.
SWMBH Policy 6.4 Customer Grievance Systems & Second Opinions

Attachments:

A. P12.08.01A ABA Services Referral
B. P12.08.01B Ineligibility Notification – Autism Benefit Enrollee
C. P12.08.01C Training Verification Attachment to IPOS
D. P12.08.01D ABA Provider Clinical Quality Review Tool
E. P12.08.01E Child Clinical Quality Record Review
F. P12.08.01F BCABA Provider Qualifications
G. P12.08.01G BCBA or BCBA-D Provider Qualifications
H. P12.08.01H BT Provider Qualifications
I. P12.08.01I LP/LLP Provider Qualifications
J. P12.08.01J QBHP Provider Qualifications
K. P12.08.01K QLP Provider Qualifications
L. P12.08.01L ABA Authorization Review Instructions
M. P12.08.01M BCBA Consultation Form

Southwest Michigan BEHAVIORAL HEALTH

Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
1	6/25/2020	Full policy, procedure: screening and referral, authorizations, BCBA consultation for denials, ABA provider reviews	Transferred procedure to new template, added additional details for screening and referral/authorization sections, added BCBA consultation for denials section, updated ABA provider review tools. Added all relevant/updated attachments	J. Franklin
2	1/25/2022	Procedure: A, C, E, F (added new section "F" and re-ordered the following procedure lettering). References.	Adding information regarding denials of ABA and untimely decision denials.	H. Woods

2.16.22 P12.08.01 Applied Behavior Analysis (ABA)

Final Audit Report 2022-02-28

Created:	2022-02-25
By:	Jody Vanden Hoek (jody.vandenhoek@swmbh.org)
Status:	Signed
Transaction ID:	CBJCHBCAABAAsl-BwVvr-pLmxTkR-ih0zKdLdly0y_Fw

"2.16.22 P12.08.01 Applied Behavior Analysis (ABA)" History

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Agreement completed.
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Adobe Sign

WSA Case number (PIHP use only) _____

Southwest Michigan BEHAVIORAL HEALTH

August 2019

Behavioral Health Treatment - ABA Services Referral Form

Date _____

Medicaid ID # _____ *or* MiChild ID# _____

Member's Name _____ Date of Birth _____

CMH Name _____

Referral Date (Initial discussion with family specific to ABA services prior to completion of ADOS-2) _____ ☐ N/A (Re-evaluation)

Was the child referred by a physician? ☐ Yes ☐ No

Was an ADI-R (or equivalent) completed? ☐ Yes ☐ No

Evaluation Date (ADOS-2) _____

ADOS-2 Overall Total Score _____

ADOS-2 (Check One):	ADOS-2 Diagnostic Code:
☐ No ADOS-2 Performed ☐ Module 1 (few to no words) ☐ Module 1 (some words) ☐ Module 2 (5 years and older) ☐ Module 2 (younger than 5 years) ☐ Module 3 ☐ Module 4 Scores: Communication _____Social Interaction_____ ☐ Toddler Module (12 to 30 months with few or no words) ☐ Toddler Module (21 to 30 months with some words)	☐ Not Qualified ☐ Autism ☐ ASD

Impairments in Social Communication & Social Interaction – Lack Of (***all must be checked to qualify***):

- ☐ Social or emotional reciprocity
- ☐ Nonverbal communicative behaviors used for social interaction
- ☐ Developing, maintaining, and understanding relationships

Restricted, repetitive and stereotypical patterns of behavior, interests, and activities (***at least two areas must be checked***):

- ☐ Stereo typed or repetitive motor movements, use of objects or speech
- ☐ Insistence on sameness, inflexible adherence to routines, or ritualized patters or verbal nonverbal behavior
- ☐ Highly restricted, fixated interests that are abnormal in intensity or focus
- ☐ Hyper or hypo activity to sensory input or unusual interests in sensory aspects of the environment

Children's Global Assessment Score (1-100): _____

Notes:

Name of practitioner Submitting this referral to SWMBH: _____Credentials_____

Name of licensed practitioner who completed the assessment: _____ Credentials _____

Please send via secure email to Jeremy.franklin@swmbh.org

Southwest Michigan
BEHAVIORAL HEALTH

Revised August 2018

Ineligibility Notification – Autism Benefit Enrollee

Member's Name or WSA Case Number _____ CMH Name _____

Exit ADOS-2 (Must be completed unless customer deceased or moved out of state)

(Check One): Exit ADOS-2 Overall Total Score _____

- ☐ No ADOS-2 Preformed
- ☐ Module 1 (few to no words)
- ☐ Module 1 (some words)
- ☐ Module 2 (5 years and older)
- ☐ Module 2 (younger than 5 years)
- ☐ Module 3
- ☐ Module 4
- ☐ Toddler Module (12 to 30 months with few or no words)
- ☐ Toddler Module (21 to 30 months with some words)

Reason for Termination (Check One):

- ☐ Met all treatment plan goals
- ☐ Voluntarily Disenrolled from Services
- ☐ Moved out of state
- ☐ Deceased
- ☐ Other _____
- ☐ Aged off (21st birthday)
- ☐ Approved – Declined Services (Approved for benefit but did not receive ABA direct service)
- ☐ Re-Evaluation did not meet medical necessity
- ☐ No longer eligible for Medicaid

Family Notified: ☐ Yes ☐ No If yes, Date Notified _____

Note: The only exception for not notifying the family in advance is in the event of the enrollee's death. For all other disenrollment reasons, the family must be notified 14 days prior to the action.

Client's Social Security Number: _____

Parent/Guardian's Name: _____

Family's Mailing Address: _____

Disenrollment Date: _____

Note: Must be 14 days from date of noting the family

Hearing Requested:

- ☐ Yes Date of Hearing _____
- ☐ No

Name of licensed practitioner completing this document: _____ Credentials_____

Signature of licensed practitioner completing this document: _____

Secure email to jeremy.franklin@swmbh.org or fax to SWMBH at (269) 488-8270

Training Verification Attachment to IPOS

_____ (customer)

_____ (case number)

_____ IPOS/Addendum date

The following staff were trained on the

- ABA interventions and techniques indicated IPOS
- applied behavioral plan
- interventions and objectives
- methods to communicate expectations and feedback
- aspects for reporting the results of training

_____ (ABA Aide) _____ (date)

_____ (ABA Aide) _____ (date)

_____ (ABA Aide) _____ (date)

_____ (_____) _____ (date)

_____ (_____) _____ (date)

_____ (BCBA) _____ (date)

SWMBH Behavioral Health Services
ABA Provider Clinical Review Tool 2020

Southwest Michigan
BEHAVIORAL HEALTH

	Provider:				
	Date of Review:				
	Section A: Case Coordination	**Possible**	**Actual**	**Average**	**Previous**
1	Coordination with the CMHSP case manager is documented.				
			Section Average:		
	Section B: Treatment Planning	**Possible**	**Actual**	**Average**	**Previous**
1	Comprehensive ABA behavioral treatment plan is present and is updated at minimum annually.				
2	Plan is individualized based upon assessment of the customer's needs and preferences.				
3	Goals are measurable, achievable and realistic.				
4	Plan addresses risk factors identified for the child and family.				
5	Family Training is present within the treatment plan or there is documentation that the family declined.				
6	Services are provided as specified in the providers IPOS including amount, scope, duration.				
7	Behavioral Technicians, Occupatoinal Therapists, Physical Theraspists etc. have been trained in the **IPOS,** any applicable plan **Addendums,** and any applicable **Support Plan** (Behavior Treatment Plan, PT/OT/Nursing Plan, etc.) for individuals in their care, before the provision of direct care.				
			Section Average:		
	Section C: Progress Notes	**Possible**	**Actual**	**Average**	**Previous**
1	Progress notes reflects which goal(s)/objective(s) were addressed during the contact.				
2	Progress notes reflect the customer's progress toward goals/objectives.				
3	If applicable, the record contains evidence of follow up attempts to engage customer after no shows/missed appointments (phone calls, letters, etc.).				
			Section Average:		
	Section D:Evaluation/Re-Evaluation	**Possible**	**Actual**	**Average**	**Previous**
1	Ongoing determination of service level has evidence of measurable and ongoing improvement in targeted behaviors as demonstrated with ABLLS-R or VB-Mapp. Other documentation of analysis may be accepted (i.e. graphs, assessment, reports, records of service, progress reports etc.)				
2	Documentation is present within the file on parent engagement (phone calls, family training, collatoral contacts etc.)				
3	Documentation is present within the file to show that ABA services are not supplanting special education services (if applicable.)				
4	If individual is out of school and attending ABA, a plan/criteia is present to return to a traditional school enviornment.				
5	Ongoing progress is documented at minimum every six months.				

SWMBH Behavioral Health Services
ABA Provider Clinical Review Tool 2020

Southwest Michigan
BEHAVIORAL HEALTH

6	A discharge plan is present.				
			Section Average:		
				FY 20 Overall Score:	Previous Overall Score:

SWMBH
Child Clinical Quality Record Review

Southwest Michigan BEHAVIORAL HEALTH

Case #:			
Name			
Provider:			
Date of Review:			
Reviewer:			
A	**Section A: Physician Coordination**	**Possible**	**Actual**
1	The file contains consent to share treatment information between the provider/CMH, the PIHP, the primary care physician, the customer and their health plan, or documentation of refusal.		
2	If the customer has no PCP, the record contains documentation that a referral to a PCP has been made.		
3	If the customer has a PCP and has signed a release, the record contains documentation of correspondence with the physician to coordinate care. This should include minimally, sending primary assessment, treatment plan updates, changes in level of care, med changes, etc., to PCP. Actual contact (phone/in person) with physician is also counted/encouraged.		
4	The CMH will ensure that a basic health care screening, including height, weight, blood pressure, and blood glucose levels is performed on individuals ***who have not visited a primary care physician, even after encouragement, for more than 12 months.*** Health conditions identified through screening should be brought to the attention of the individual/family along with information about the need for intervention and how to obtain it. (Consultative for FY17)		
5	Services requiring physician signed prescription follow Medicaid Provider Manual requirements. (Evidence: Physician-signed prescriptions for OT and PDN services are in the file and include a date, diagnosis, specific service or item description, start date and the amount or length of time the service is needed).		
	Comments (Required for any score of 1 or 0):	0	0
B	**Section B: Assessment**	**Possible**	**Actual**
1	Level of Functioning/Daily Living is appropriately evaluated and identifies a functional deficit requiring intervention/treatment. CAFAS/PECFAS completed quarterly and at discharge. LOCUS completed annually. SIS completed once every three years (N/A if no SIS during initial 3 year implementation period).		
2	The psychosocial assessment identifies the customer's strengths.		
3	Clinical analysis and interpretive summary of the customer's identified needs and priorities, and a professional opinion of service needs and recommendations are recorded.		
	Comments (Required for any score of 1 or 0):	0	0
C	**Section C: Treatment Plan/Person-Centered Planning**	**Possible**	**Actual**
	The written treatment plan shall conform to all the following:		
1	Pre-planning meets the following elements: 1 - completed prior to actual planning meeting; 2- Customer is offered a choice of external facilitator; 3 - Self-determination is offered; 4 - Choice of when/where the planning meeting is to be held is given; 5 - choice of who will attend the meeting is given.		
2	The treatment plan is developed in a timely manner from initial assessment, and updated at a minimum of every 365 days.		
3	Is individualized based upon assessment of the client's needs.		

SWMBH
Child Clinical Quality Record Review

Case #:			
Name			
Provider:			
Date of Review:			
Reviewer:			
4	Define the services to be provided to the client, including amount, scope, and duration.		
5	Contain clear, concise and measurable statements of the goals and objectives the customer will be attempting to achieve.		
6	Each objective includes interventions that will be used to assist the customer in being able to accomplish the objective.		
7	Customer/guardian was offered the opportunity to develop a Crisis/Safety Plan. If risk of harm to self or others has been identified a crisis plan has been completed.		
8	Plan was provided to customer within 15 days of meeting unless there is documentation that a copy was not wanted.		
9	There is evidence in the file to support that all Aides (defined in MDHHS Provider Qualifications) serving the customer have been trained on the IPOS.		
	Comments (Required for any score of 1 or 0):	0	0
D	**Section D: Progress Notes**	**Possible**	**Actual**
1	Progress notes reflects which goal(s)/objective(s) were addressed during the treatment contact and the customer's progress toward the goal.		
2	Services and treatment identified in the IPOS are provided as specified in the plan, including measurable goals/objective, the type, amount, scope, duration, frequency and timeframe for implementing.		
	Comments (Required for any score of 1 or 0):	0	0
E	**Section E: Periodic Review**	**Possible**	**Actual**
1	Periodic reviews must occur at the frequency agreed upon in the IPOS and when there are changes in needs.		
2	Individuals are provided with ongoing opportunities to provide feedback on how they feel about services, perceived barriers or strengths during treatment, supports and/or treatment they are receiving, and their progress towards attaining valued outcomes. (May be documented in Progress notes and/or Periodic Reviews).		
3	Periodic reviews document progress toward goals and objectives and identify any events that have affected outcomes.		
	Comments (Required for any score of 1 or 0):	0	0
F	**Section F: TEDS and Customer Discharge/Transfer**	**Possible**	**Actual**
1	TEDS admission is completed fully and accurately		
2	TEDS discharge documentation was completed fully and accurately and within 45 days of service for unplanned discharges and 5 days for planned discharges.		
	Comments (Required for any score of 1 or 0):	0	0
G	**Section G: Utilization Management**	**Possible**	**Actual**

SWMBH
Child Clinical Quality Record Review

Case #:			
Name			
Provider:			
Date of Review:			
Reviewer:			
1	Service authorization decisions were made no later than 14 calendar days following receipt of a request for service authorization, unless the PIHP has authorized an extension; and no later than 3 days following receipt of a request for expedited service authorization, if warranted by the consumer's health or functioning, unless the PIHP has authorized an extension. (N/A if aggregate report is provided).		
2	Customer eligibility and appropriateness are clearly documented. Decisions are made based on CMH's identified medical necessity criteria.		
3	Case reviewed by utilization management staff when initial authorization is used.		
	Comments (Required for any score of 1 or 0):	0	0
H	**Section H: Behavior Treatment Planning**	**Possible**	**Actual**
1	In the event that a Behavior Treatment Plan is in place, there is evidence in the file to show that the plan has been presented and approved by the Behavior Treatment Committee (BTC).		
2	For each approved plan, there is a set and documented date to re-examine the continuing need for the approved procedures. This review shall occur at a frequency that is clinically necessary or as requested by the individual in the person centered planning process. (at minimum quarterly for plans that include intrusive or restrictive interventions)		
3	The plan demonstrates that less restrictive interventions have been attempted and were unsuccessful.		
4	There is evidence in the file to show that the customer / guardian signed off on the plan?		
	Comments (Required for any score of 1 or 0):	0	0
H	**Section I: Record Keeping**	**Possible**	**Actual**
1	Adequate/Advanced Notice was provided within the required time frames (Adequate Notice was given to and reviewed with the customer at the time of action; Advance Notice was sent 12 days in advance of the action).		
2	Adequate/Advanced Notice was completed fully and correctly.		
3	There is evidence that the consumer received the SWMBH Member Handbook at intake and annually thereafter.		
4	There is evidence in the file that the customer has been provided a cost service estimate for all authorized services each time an IPOS is created or changed.		
	Comments (Required for any score of 1 or 0):	0	0
		Overall Score:	

SWMBH
Child Clinical Quality Record Review
Scoring Guide

		Scoring: 2 = Fully compliant with all requirements 1* = Partially compliant with requirements 0* = Not compliant NA = Not applicable-put this in the box next to the score box so that it does not interfere with automatic calculations. **An explanation describing the partially compliant or noncompliant findings will be provided in the "Comments" box within each section of the audit tool.*
A	**Section A: Physician Coordination**	
1	The file contains consent to share treatment information between the provider/CMH, the PIHP, the primary care physician, the customer and their health plan, or documentation of refusal	2 - The file contains a completed release of information that includes the provider/CMH, the PIHP, the primary care physician, the customer and their health plan; or there is documentation of refusal to complete the release of information. 1 - The file contains a release of information that is not completed; or release of information does not contain all entities. 0 - The file does not contain any consent to share information or documentation showing the family declined assistance with health care coordination.
2	If the customer has no PCP, the record contains documentation that a referral to a PCP has been made,	2 - The file contains documentation of a referral to a PCP in the event that no PCP has been identified. 0 - The file contains no documentation regarding a PCP referral or coordination of healthcare.
3	If the customer has a PCP and has signed a release, the record contains documentation of correspondence with the physician to coordinate care. This should include minimally, sending primary assessment, treatment plan updates, changes in level of care, med changes, etc., to PCP. Actual contact (phone/in person) with physician is also counted/encouraged.	2 - The file contains in depth supporting documentation of health care coordination in the event that there is a signed release in place (ongoing correspondence with the physician, assessment information, treatment plan updates, changes in levels of care/services, med changes etc. 1 - Correspondence and documentation of coordination is present, but does not happen as frequent as the customer needs it (i.e. may be missing for an inpatient hospitalization, change in level of care/services, change of medication etc.) 0 - There is no evidence of ongoing coordination of care.

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4	The CMH will ensure that a basic health care screening, including height, weight, blood pressure, and blood glucose levels is performed on individuals who have not visited a primary care physician, even after encouragement, for more than 12 months. Health conditions identified through screening should be brought to the attention of the individual/family along with information about the need for intervention and how to obtain it.	2- Individual has been screened for basic health care within the past year. Screening includes weight, blood pressure, and blood glucose levels and there is evidence that identified health related issues have been followed up on. (i.e. letters/referrals to primary care doctor/coordination of care) 1 - Individual completed basic health care screening, however health issues have not been followed up on; or health screen only contains some of the required elements. 0 - No evidence of basic health care screening or subsequent referral to primary care doctor if the customer has not been screened within a year.
6	Services requiring physician signed prescription follow Medicaid Provider Manual requirements. (Evidence: Physician-signed prescriptions for OT and PDN services are in the file and include a date, diagnosis, specific service or item description, start date and the amount or length of time the service is needed).	2- Current prescriptions are in the record for required services and are fully completed. 1 - Prescriptions are in the record but are mission some elements (e.g., diagnosis) 0 - No prescriptions are in the record, or they are out of date.
B	**Section B: Assessment**	
1	Level of Functioning/Daily Living is appropriately evaluated and identifies a functional deficit requiring intervention/treatment. CAFAS/PECFAS or DECA completed quarterly and at discharge. LOCUS completed annually. SIS completed once every three years.	2 - Appropriate level of functioning tool has been utilized and supports the description of the consumer's current functioning and treatment. 1 - The level of functioning/daily living is underdeveloped and/or vague; or assessment tool has not been completed within appropriate timeframe; or the level of functioning in the assessment does not align with the outcome of the appropriate tool 0 - There is no documentation of appropriate assessment tool being utilized.
2	The psychosocial assessment identifies the customer's strengths.	2 - The consumer's strengths have been clearly identified and documented in the psychosocial assessment. 1 - The psychosocial assessment is generic or vague when listing out specific strengths of the consumer/family. 0 - The psychosocial assessment does not contain documentation of the consumer's strengths.

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3	Clinical analysis and interpretive summary of the customer's identified needs and priorities, and a professional opinion of service needs and recommendations are recorded.	2 - Clinical analysis is current and briefly indicates what treatment is recommended for the consumer based on specific signs, symptoms, needs, priorities and consumer strengths that have been self-identified by the consumer. 1 - Clinical analysis is not current and/or does not fully indicate treatment recommendations based on specific signs, symptoms, needs, priorities or consumer needs. 0 - Clinical analysis is not current AND fails to establish specific needs, priorities or consumer needs or fails to establish specific treatment recommendations.
4	Evidence that a qualifying ADOS-2 has been completed within the past year and or is completed a minimum of once a year.	2 - There is evidence on file to show proof that the ADOS-2 ahs been completed within the past year or is completed a minimum of once per year. 1- There is evidence on file that the ADOS-2 has been completed, but it may not be timely (i.e. surpasses a year between assessments) 0 - There is no evidence on file that an ADOS- 2 has been completed.
5	Evidence that an ADI-R, or clinical equivalent, has been completed as part of the comprehensive assessment done at the onset of ABA services.	2 - There is evidence in the file to show that the ADIR has been completed as part of the comprehensive assessment done at the onset of ABA services. 0 - There is no evidence of an ADI-R, or clinical equivalent, has been completed as part of the comprehensive assessment done at the onset of ABA services.
C	**Section C: Treatment Plan/Person-Centered Planning**	
	The written treatment plan shall conform to all the following:	
1	Pre-planning meets the following elements: 1 - completed prior to actual planning meeting; 2- Customer is offered a choice of external facilitator; 3 - Self-determination is offered; 4 - Choice of when/where the planning meeting is to be held is given; 5 - choice of who will attend the meeting is given.	2 - Documentation is present to show all elements of pre-planning. 1 - Some elements of pre-planning are present. 0 - There is no documentation of pre-planning.

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2	The treatment plan is developed in a timely manner and updated at a minimum of every 365 days.	2 - A signed treatment plan is present in the client's file and subsequent treatment plans are developed prior to the 365 day expiration date. 1 - There is a signed treatment plan, but there is an extended period between the assessment and the plan; or the subsequent treatment plan was developed after the 365 expiration date. 0 - There is no treatment plan present for this client.
3	Is individualized based upon assessment of the client's needs.	2 - Treatment plan is individualized and it is based on assessment of the client's needs. All needs have been addressed. 1 - Treatment plan addresses some needs, but not all needs identified in the assessment and/or Treatment plan reflects goals that have not been identified s a need in the assessment. 0 - Treatment plan is general and could be used for virtually any person involved in services.
4	Define the services to be provided to	2 - All required elements present (amount, scope and duration) 1 - One or two of the required elements are missing (i.e. amount and scope of services present, but duration is missing.) 0 - Several or all of the listed elements are missing
5	Contain clear, concise and measurable statements of the goals and objectives the customer will be attempting to achieve.	2 - Goals are clearly measurable in an objective way (goals contain quantifiers that make them clearly measurable.) 1 - Goals are measurable as a matter of the clinician's opinion; subjective 0 - No apparent way to measure progress
6	Each objective includes interventions that will be used to assist the customer in being able to accomplish the objective.	2 - Specific interventions are associated with each objective in the treatment plan and are individualized to the customer 1 - Basic or broad interventions are associated with each objective in the treatment plan; or one or two objectives are lacking associated interventions; or Interventions are not individualized. 0 - One or two word interventions are listed; or Interventions are not associated with any objectives

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7	Customer/guardian was offered the opportunity to develop a Crisis/Safety Plan. If risk of harm to self or others has been identified a crisis plan has been completed.**(required for home-based services)**	2 - It is clearly documented that an offer was made to complete a crisis plan (in the event that a risk has been identified) and the client declined or accepted. If a plan was completed, it was detailed and addresses the specific risks identified 1 - There is a brief reference in the assessment, or identified risk section, that an offer was made to complete a plan; or it is not clear if the client declined or accepted; or plan is documented, but is not detailed or vague. 0 - There is no evidence that a crisis plan was developed or discussed with the client.
8	Plan was provided to customer within 15 days of meeting unless there is documentation that a copy was not wanted.	2 - A copy of the plan was provided to the customer within 15 days of plan completion or documentation is present in the file indicating that a copy of the plan was declined. 1 - A copy of the plan was provided to the customer more than 15 days after the plan was completed. 0 - There is no documentation to show that a copy of the plan was provided or declined.
9	There is evidence in the file to support that all Aides (defined in MDHHS Provider Qualifications) serving the customer have been trained on the IPOS.	2 - There is documentation in the file to support that any Aide assisting on the case has been trained on the IPOS. 0 - There is no evidence in the file to show that all Aides serving the customer have been trained in the IPOS.
10	Is individualized based upon the VB-MAPP, ABLLS or AFLS.	2 - The goals reflect individualization based upon the VB-MAPP, ABLLS or AFLS. 1 - Only some of the goals reflect individualization based on the VB-MAPP, ABLLS or AFLS. 0 - None of the goals are associated/individualized based on the VB-MAPP, ABLLS or AFLS.
D	**Section D: Progress Notes**	

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1	Progress notes reflects what goal(s)/objective(s) were addressed during the treatment episode and the customer's progress toward the goal.	2 - Progress notes reflect information that incorporates specific goals and objectives from the treatment plan and clearly link the client's progress towards the specified goal. 1 - Progress note is vague or has a general language that could be used for many other people; or progress note is detailed, but does not incorporate goals and objectives addressed in the treatment plan; or progress note does not clearly define customer progress toward identified goal. 0 - The progress note does not reflect what was addressed during the treatment episode and does not report on progress towards the goal. The note may be vague or contains general language that could be used for many other people and does not incorporate goals and objectives from the treatment plan.
2	Services and treatment identified in the IPOS are provided as specified in the plan, including measurable goals/objective, the type, amount, scope, duration, frequency and timeframe for implementing.	2 – Services and treatment documented clearly outline progress toward identified goals/objectives. Interventions and outcomes are documented on all or nearly all progress notes. Services documented align with the type, amount, scope, duration, frequency and timeframes outlined in the plan. 1 – Services and treatment outlined provide some progress, interventions and outcomes are documented inconsistently or are overly general. Services may not include all elements (type, scope, duration, frequency, and timeframes.) 0 – Little or no documentation of specific interventions/outcomes or goal/objective status in the progress notes. Documentation does not align with what is specified in the plan in terms of amount, scope, duration, frequency and timeframes.
3	There is evidence in the file to show that the customer/family is receiving at minimum 4 hours of face to face service per month (unless there is documentation of transition to a less intensive service).	2 - Face to face hours total at least four hours per month or there is documentation to show that the family is transitioning to a less intensive service. 1 - Face to face hours average less than four hours per month and there is little documentation to show why this level of service is not being achieved. 0 - Face to face hours of service per month are less than two hours on average and there is little to no documentation to show rationale or reason of why the service intensity is not being achieved.
E	**Section E: Periodic Review**	
1	Periodic reviews must occur at the frequency agreed upon in the IPOS and when there are changes in needs.	2 – There is documentation that a detailed periodic review has been completed at least once every six months and/or when there has been a change in needs. 1 – The periodic review did not take place within the six month timeframe. 0 – There is no evidence that a periodic review took place

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2	Individuals are provided with ongoing opportunities to provide feedback on how they feel about services, perceived barriers or strengths during treatment, supports and/or treatment they are receiving, and their progress towards attaining valued outcomes. (May be documented in Progress notes and/or Periodic Reviews).	2 – There is documentation that outlines that a clinician has discussed satisfaction with services with client and/or guardian. Feedback and barriers were clearly discussed and documented as well as the potential impact on services 1 – There is documentation that service satisfaction was discussed; however the documentation was vague and/or feedback wasn't taken into consideration for future services being delivered. Barriers may not have been identified or customer's thoughts on progress has not been documented. 0 – There is no evidence that treatment is being discussed or feedback is being taken into account. There is no documentation about perceived barriers and how they may be impacting treatment.
3	Periodic reviews document progress toward goals and objectives and identify any events that have affected outcomes.	2 – Periodic reviews clearly document progress towards each goal and objective. Updates have been provided that may have affected outcomes. 1 – Periodic review documents vague progress that is not linked specifically to each goal/objective. The record may or may not contain updates that have impacted outcomes. 0 – There is no documentation on progress towards treatment goals or events that may have impacted outcomes.
4	Need and rationale for continued and/or additional services is clearly identified. Plan addendums are created for any additional services.	2 - Periodic review clearly documents continued need for identified services. In the event that additional services are needed due to a change in level of functioning, plan addendums have been developed to address those specific needs. 1 - Periodic review does not capture progress and justify the need for ongoing services; and/or addendums have not been created when a new need has been identified in the periodic review. 0 - Periodic review does not clearly document the need for ongoing services, yet services have not been discontinued.
5	Ongoing assessments for customers receiving Applied Behavior Analysis services are completed every six months (VB-MAPP/ABLLS/AFLS) and periodic review of the IPOS is completed every three months.	2 - Ongoing assessments and periodic reviews are occurring as required. 1- Ongoing assessments and periodic reviews are sometimes late 0 - Ongoing assessments and periodic reviews are not occurring as outlined at all or are missing completely.
F	**Section F: TEDS and Customer Discharge/Transfer**	

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1	TEDS admission is completed fully and accurately	2 – A completed TEDS admission documented in the client's file. 1 – A TEDS admission is documented, however it is "in progress" or has not been completed accurately to override validations. 0 – There is no TEDS admission documented; or there is only a standard admission document present.
2	TEDS discharge documentation was completed fully and accurately and within 45 days of service for unplanned discharges and 5 days for planned discharges.	2 – The TEDS discharge documentation is present in the client's file and is done so in the aforementioned timeframe above. 1- The TEDS discharge document is present, but is "in progress" or has not been completed 0 – The TEDS document has not been completed accurately or the TEDS discharge documentation was not completed and documented in the aforementioned time frame above.
G	**Section G: Utilization Management**	
1	Service authorization decisions were made no later than 14 calendar days following receipt of a request for service authorization, unless the PIHP has authorized an extension; and no later than 3 days following receipt of a request for expedited service authorization, if warranted by the consumer's health or functioning, unless the PIHP has authorized an extension. (N/A if aggregate report is provided).	2 - There is evidence in the file to show that authorization decisions have been made in the timeframes outlined. 1 - There is evidence in the file to show that the authorization decisions have been made, however they fall outside of the outlined timeframes. 0 - There is no evidence in the file to show that authorization decisions have been made.
2	Customer eligibility and appropriateness are clearly documented. Decisions are made based on CMH's identified medical necessity criteria.	2 - There is evidence in the file to show that customer eligibility and appropriateness is clearly linked to medical necessity criteria. 0 - There is no evidence in the file to show that the customer eligibility and appropriateness is clearly linked to medical necessity criteria.
3	Case reviewed by utilization management staff when initial authorization is used.	2 - There is evidence in the file to show that utilization management staff have reviewed the case when the initial authorization is used. 0 - There is no evidence in the file to show that utilization management staff have reviewed the case when the initial authorization is used.
H	**Section H: Behavior Treatment Planning**	

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Scoring Guide

1	In the event that a Behavior Treatment Plan is in place, there is evidence in the file to show that the plan has been presented and approved by the Behavior Treatment Committee (BTC).	2 - There is evidence in the file to show that the plan has been presented and approved by the Behavior Treatment Committee (BTC). 0 - There is no evidence in the file to show that the plan has been presented and approved by the BTC.
2	For each approved plan, there is a set and documented date to re-examined the continuing need for the approved procedures. This review shall occur at a frequency that is clinically necessary or as requested by the individual in the person centered planning process. (at minimum quarterly for plans that include intrusive or restrictive interventions)	2 - There is evidence in the file to show that the plan has a set date to re-examine the continuing need for the approved procedures, at minimum quarterly.) 1- There is evidence in the file to show that there is a set date to re-examine the continuing need for the approved procedures, however this date is not consistently being adhered to. 0 - There is no evidence in the file that the plan has a set date for re-examining the plan.
3	The plan demonstrates that less restrictive interventions have been attempted and were unsuccessful.	2 - There is evidence in the file to show that less restrictive interventions have been attempted and were unsuccessful. 0 - There is no evidence in the file to show that a less restrictive intervention has been attempted.
4	There is evidence in the file to show that the customer / guardian signed off on the plan.	2 - There is documentation to show that the customer /guardian has signed off on the plan. 0 - There is no evidence of the customer/guardian signing off on the plan.
I	**Section I: Record Keeping**	
1	Adequate/Advanced Notice was provided within the required time frames (Adequate Notice was given to and reviewed with the customer at the time of action; Advance Notice was sent 12 days in advance of the action).	2 - Adequate/Advanced notice was provided within the required timeframes. 1 - Adequate/Advanced notice was provided, but not within appropriate timeframes 0 - Adequate/Advanced Notice was not provided.

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Scoring Guide

2	Adequate/Advanced Notice was completed fully and correctly.	2 - Notice includes: name/ID number of customer, date of action or effective date of change (advanced notice), name of services affected, reason for action, due process rights for available appeal processes 1 - One non-essential item is missing (case number missing) 0 - More than one essential element is missing from the notice (i.e. date, reason for notice etc.) .
3	There is evidence that the consumer received the SWMBH Member Handbook at intake and annually thereafter.	2 - There is evidence in the file that the customer received the SWMBH Member Handbook annually and thereafter. 0 - There is no evidence in the file that the customer has been provided the member handbook annually and thereafter.
4	There is evidence in the file that the customer has been provided a cost service estimate for all authorized services each time an IPOS is created or changed.	2 - There is evidence in the file to show that the customer has been provided a cost service estimate for all authorized services each time an IPOS is created or changed. 1 - There is evidence in the file to show that the customer has been provided a cost service estimate annually, however it is not completed each time a goal is added or changed. 0 - There is no evidence in the file to show that the customer has been provided a cost service estimate.

MICHIGAN AUTISM PROGRAM

ASD-ABA Services Supervisor Staff Review- BCaBA

PIHP:	CMH/Provider:	Site Visit Date:
Primary WSA Case(s):	**Oversample WSA Case(s):**	**MDHHS Reviewer:**

18.12 Medicaid Provider Manual: Behavioral Health Treatment-ABA services are highly specialized services that require specific qualified providers who are available within PIHP/CMHSP provider networks and have extensive experience providing specialty mental health and behavioral health services.
PLEASE NOTE: YOU MUST BE ABLE TO PROVIDE DOCUMENTED EVIDENCE DURING THE SITE REVIEW THAT SHOW YOU MEET THESE FEDERAL REQUIREMENTS.

MDHHS VERIFIED	
	Board Certified Assistant Behavior Analyst (BCaBA) Name:_____
	Employed by: _____
☐	Date of Hire: ____/_____/_____ (*Please provide Employer letter, HR documentation, or other documentation*)
☐	Date of 1st & last Criminal Background Checks: ____/_____/_____ & ____/_____/_____ *(Please provide documentation)*
☐	Holds a current certification as a BCaBA through the Behavior Analyst Certification Board (BACB) *(Please provide a copy of BCaBA certificate & BCaBA certificate expiration date: ___/___/___)*
☐	**Works under the supervision of a BCBA** BCBA Name: _____ *(Please provide supervision documentation from BCBA)*

MDHHS

MICHIGAN AUTISM PROGRAM

ASD-ABA Services Supervisor Staff Review- BCaBA

PIHP:	CMH/Provider:	Site Visit Date:
Primary WSA Case(s):	Oversample WSA Case(s):	MDHHS Reviewer:

18.12 Medicaid Provider Manual: Behavioral Health Treatment-ABA services are highly specialized services that require specific qualified providers who are available within PIHP/CMHSP provider networks and have extensive experience providing specialty mental health and behavioral health services.
PLEASE NOTE: YOU MUST BE ABLE TO PROVIDE DOCUMENTED EVIDENCE DURING THE SITE REVIEW THAT SHOW YOU MEET THESE FEDERAL REQUIREMENTS.

MDHHS VERIFIED	
	Board Certified Assistant Behavior Analyst (BCaBA) Name:_____
	Employed by: _____
☐	Date of Hire: ____/_____/_____ (*Please provide Employer letter, HR documentation, or other documentation*)
☐	Date of 1st & last Criminal Background Checks: ____/_____/_____ & ____/_____/_____ *(Please provide documentation)*
☐	Holds a current certification as a BCBA through the Behavior Analyst Certification Board (BACB) *(Please provide a copy of BCaBA certificate & BCaBA certificate expiration date: ___/___/___)*
☐	**Works under the supervision of a BCBA** BCBA Name: _____ *(Please provide supervision documentation from BCBA)*

MDHHS

MICHIGAN AUTISM PROGRAM

ASD-ABA Services Supervisor Staff Review- BCBA or BCBA-D

PIHP:	CMH/Provider:	Site Visit Date:
Primary WSA Case(s):	**Oversample WSA Case(s):**	**MDHHS Reviewer:**

18.12 Medicaid Provider Manual: Behavioral Health Treatment-ABA services are highly specialized services that require specific qualified providers who are available within PIHP/CMHSP provider networks and have extensive experience providing specialty mental health and behavioral health services.
PLEASE NOTE: YOU MUST BE ABLE TO PROVIDE DOCUMENTED EVIDENCE DURING THE SITE REVIEW THAT SHOW YOU MEET THESE FEDERAL REQUIREMENTS.

MDHHS VERIFIED	
	Board Certified Behavior Analyst (BCBA or BCBA-D) Name:_____
	Employed by: _____
☐	Date of Hire: ____/_____/_____ (*Please provide Employer letter, HR documentation, or other documentation*)
☐	Date of 1st & last Criminal Background Checks: ____/_____/_____ & ____/_____/_____ *(Please provide documentation)*
☐	Holds a current certification as a BCBA through the Behavior Analyst Certification Board (BACB) *(Please provide a copy of BCBA certificate & BCBA certificate expiration date: ___/___/___)*

MDHHS

MICHIGAN

ASD-ABA Services Supervisor Staff Review- BCBA or BCBA-D

PIHP:	CMH/Provider:	Site Visit Date:
Primary WSA Case(s):	**Oversample WSA Case(s):**	**MDHHS Reviewer:**

18.12 Medicaid Provider Manual: Behavioral Health Treatment-ABA services are highly specialized services that require specific qualified providers who are available within PIHP/CMHSP provider networks and have extensive experience providing specialty mental health and behavioral health services.

PLEASE NOTE: YOU MUST BE ABLE TO PROVIDE DOCUMENTED EVIDENCE DURING THE SITE REVIEW THAT SHOW YOU MEET THESE FEDERAL REQUIREMENTS.

MDHHS VERIFIED	
	Board Certified Behavior Analyst (BCBA or BCBA-D) Name:_____
	Employed by: _____
☐	Date of Hire: ____/_____/_____ (*Please provide Employer letter, HR documentation, or other documentation*)
☐	Date of 1st & last Criminal Background Checks: ____/_____/_____ & ____/_____/_____ *(Please provide documentation)*
☐	Holds a current certification as a BCBA through the Behavior Analyst Certification Board (BACB) *(Please provide a copy of BCBA certificate & BCBA certificate expiration date: ___/___/___)*

MDHHS

MICHIGAN AUTISM PROGRAM

ASD-ABA Services Staff Review- Behavior Technician

PIHP:	CMH/Provider:	Site Visit Date:
Primary WSA Case(s)	**Oversample WSA Case(s):**	**MDHHS Reviewer:**

18.12 Medicaid Provider Manual: Behavioral Health Treatment-ABA services are highly specialized services that require specific qualified providers who are available within PIHP/CMHSP provider networks and have extensive experience providing specialty mental health and behavioral health services.

PLEASE NOTE: YOU MUST BE ABLE TO PROVIDE DOCUMENTATED EVIDENCE DURING THE SITE REVIEW THAT SHOW PROVIDERS MEET THESE FEDERAL REQUIREMENTS.

MDHHS VERIFIED	
	Name: _____
	Employed by: _____
☐	Date of Hire: ____/____/_____ (*Please provide Employer letter, HR documentation, or other documentation*)
☐	Date of 1st & last Criminal Background Checks: ____/____/_____ & ____/____/_____ (*Please provide documentation*)
☐	18 years of age? Date of Birth: ____/____/_____ (*Please provide Driver's License, state identification, or other documentation*)
☐	Able to protect against the transmission of communicable diseases? (*Please provide training date ___/___/___ & certificate, or other documentation*)
☐	Able to perform and be certified in basic First Aid procedures? (*Please provide training date ___/___/___ & certificate, or other documentation*)
☐	Received beneficiary-specific IPOS/ behavioral plan of care training? (*Please provide training date ___/___/___ & certificate, or other documentation*)
☐	Able to communicate expressively & receptively in order to follow IPOS requirements, emergency procedures, and report on activities performed? (*Please provide college/university diploma, documentation from BCBA indicating Aide possess these skills, or job description requiring these skills*)
☐	Received BACB approved training outlined in the Registered Behavior Task List? (*Please provide training date ___/___/___ & objectives, or other documentation*)

MDHHS

MICHIGAN AUTISM PROGRAM

ASD-ABA Services Staff Review- Behavior Technician

PIHP:	CMH/Provider:	Site Visit Date:
Primary WSA Case(s)	**Oversample WSA Case(s):**	**MDHHS Reviewer:**

18.12 Medicaid Provider Manual: Behavioral Health Treatment-ABA services are highly specialized services that require specific qualified providers who are available within PIHP/CMHSP provider networks and have extensive experience providing specialty mental health and behavioral health services.
PLEASE NOTE: YOU MUST BE ABLE TO PROVIDE DOCUMENTATED EVIDENCE DURING THE SITE REVIEW THAT SHOW PROVIDERS MEET THESE FEDERAL REQUIREMENTS.

MDHHS VERIFIED	
	Name: _____ Employed by: _____
☐	Date of Hire: ____/____/_____ (*Please provide Employer letter, HR documentation, or other documentation*)
☐	Date of 1st & last Criminal Background Checks: ____/____/_____ & ____/____/_____ (*Please provide documentation*)
☐	18 years of age? Date of Birth: ____/____/_____ (*Please provide Driver's License, state identification, or other documentation*)
☐	Able to protect against the transmission of communicable diseases? (*Please provide training date ___/___/___ & certificate, or other documentation*)
☐	Able to perform and be certified in basic First Aid procedures? (*Please provide training date ___/___/___ & certificate, or other documentation*)
☐	Received beneficiary-specific IPOS/ behavioral plan of care training? (*Please provide training date ___/___/___ & certificate, or other documentation*)
☐	Able to communicate expressively & receptively in order to follow IPOS requirements, emergency procedures, and report on activities performed? (*Please provide college/university diploma, documentation from BCBA indicating Aide possess these skills, or job description requiring these skills*)
☐	Received BACB approved training outlined in the Registered Behavior Task List? (*Please provide training date ___/___/___ & objectives, or other documentation*)

MDHHS

MICHIGAN AUTISM PROGRAM

ASD-ABA Services Supervisor Staff Review- LP/LLP

PIHP:	CMH/Provider:	Site Visit Date:
Primary WSA Case(s):	**Oversample WSA Case(s):**	**MDHHS Reviewer:**

18.12 Medicaid Provider Manual: Behavioral Health Treatment-ABA services are highly specialized services that require specific qualified providers who are available within PIHP/CMHSP provider networks and have extensive experience providing specialty mental health and behavioral health services.
PLEASE NOTE: YOU MUST BE ABLE TO PROVIDE DOCUMENTED EVIDENCE DURING THE SITE REVIEW THAT SHOW PROVIDER MEETS THESE FEDERAL REQUIREMENTS.

MDHHS VERIFIED	
	Licensed Psychologist (LP)/ Limited Licensed Psychologist (LLP) must be certified by 9/30/2020 Name:_____
	Employed by: _____
☐	Date of Hire: ____/_____/_____ (Please provide Employer letter, HR documentation, or other documentation)
☐	Date of 1st & last Criminal Background Checks: ____/_____/_____ & ____/_____/_____ *(Please provide documentation)*
☐	Holds a doctorate (LP/ LLP) or masters (LLP) and a current state license in psychology *(Please provide a copy of your license, license expiration date ____/_____/_____ and documentation of degree)*
☐	Has documented course work at the graduate level at 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 *(Please provide transcript that documents successful completion)*
☐	Has a minimum of one year experience in treating children with ASD based on the principles of behavior analysis *(Please provide an Employer letter, job description, resume, or other documentation)*
☐	Works in consultation with a BCBA BCBA Name: _____ *(Please provide supervision documentation from BCBA)*

MDHHS

MICHIGAN AUTISM PROGRAM

ASD-ABA Services Supervisor Staff Review- LP/LLP

PIHP:	CMH/Provider:	Site Visit Date:
Primary WSA Case(s):	**Oversample WSA Case(s):**	**MDHHS Reviewer:**

18.12 Medicaid Provider Manual: Behavioral Health Treatment-ABA services are highly specialized services that require specific qualified providers who are available within PIHP/CMHSP provider networks and have extensive experience providing specialty mental health and behavioral health services.
PLEASE NOTE: YOU MUST BE ABLE TO PROVIDE DOCUMENTED EVIDENCE DURING THE SITE REVIEW THAT SHOW YOU MEET THESE FEDERAL REQUIREMENTS.

MDHHS VERIFIED	
	Licensed Psychologist (LP)/ Limited Licensed Psychologist (LLP) must be certified by 9/30/2020 Name:_____
	Employed by: _____
☐	Date of Hire: ____/_____/_____ (Please provide Employer letter, HR documentation, or other documentation)
☐	Date of 1st & last Criminal Background Checks: ____/_____/_____ & ____/_____/_____ *(Please provide documentation)*
☐	Holds a doctorate (LP/ LLP) or masters (LLP) and a current state license in psychology *(Please provide a copy of your license, license expiration date ____/_____/_____ and documentation of degree)*
☐	Has documented course work at the graduate level at 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 *(Please provide transcript that documents successful completion)*
☐	Has a minimum of one year experience in treating children with ASD based on the principles of behavior analysis *(Please provide an Employer letter, job description, resume, or other documentation)*
☐	Works in consultation with a BCBA BCBA Name: _____ *(Please provide supervision documentation from BCBA)*

MDHHS

MICHIGAN AUTISM PROGRAM

ASD-ABA Services Supervisor Staff Review- QBHP

PIHP:	CMH/Provider:	Site Visit Date:
Primary WSA Case(s):	**Oversample WSA Case(s):**	**MDHHS Reviewer:**

18.12 Medicaid Provider Manual: QBHP must meet one of the following state requirements:

1. 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
2. Hold minimum of a master's degree in a mental health-related 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.

PLEASE NOTE: YOU MUST BE ABLE TO PROVIDE DOCUMENTED EVIDENCE DURING THE SITE REVIEW THAT SHOW PROVIDER MEETS THESE FEDERAL REQUIREMENTS.

MDHHS VERIFIED	
	Qualified Behavioral Health Professional (QBHP) must be BCBA certified by 9/30/2020 Name:_____
	Employed by: _____
☐	Date of Hire: ____/_____/_____ (Please provide Employer letter, HR documentation, or other documentation)
☐	Date of 1st & last Criminal Background Checks: ____/_____/_____ & ____/_____/_____ *(Please provide documentation)*
☐	Holds a masters in a degree from an accredited institution in a mental health related field or a BACB approved degree category *(Please provide documentation of degree)* ***OR*** is a physician or licensed practitioner licensed in the State of Michigan (*Please provide documentation* of license).
☐	Has specialized training and one year experience in examination, evaluation, and treatment of children with ASD. *(Please provide an Employer letter, job description, resume, or other documentation)*
☐	Has extensive knowledge and training in behavior analysis defined as having documented course work at the graduate level at an accredited university in at least three of the six following areas. (Please provide transcript that documents successful completion) ____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

☐	Works under the supervision of a BCBA BCBA Name: _____ *(Please provide supervision documentation from BCBA)*

ASD-ABA Services Supervisor Staff Review- QBHP

PIHP:	**CMH/Provider:**	**Site Visit Date:**
Primary WSA Case(s):	**Oversample WSA Case(s):**	**MDHHS Reviewer:**

18.12 Medicaid Provider Manual: QBHP must meet one of the following state requirements:

1. 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
2. Hold minimum of a master's degree in a mental health-related 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.

PLEASE NOTE: YOU MUST BE ABLE TO PROVIDE DOCUMENTED EVIDENCE DURING THE SITE REVIEW THAT SHOW PROVIDER MEETS THESE FEDERAL REQUIREMENTS.

MDHHS	

VERIFIED	**Qualified Behavioral Health Professional (QBHP) must be BCBA certified by 9/30/2020**
	Name:_____
	Employed by: _____
☐	Date of Hire: ____/____/_____ (Please provide Employer letter, HR documentation, or other documentation)
☐	Date of 1st & last Criminal Background Checks: ____/____/_____ & ____/____/_____ *(Please provide documentation)*
☐	Holds a masters in a degree from an accredited institution in a mental health related field or a BACB approved degree category *(Please provide documentation of degree)* ***OR*** is a physician or licensed practitioner licensed in the State of Michigan (*Please provide documentation* of license).
☐	Has specialized training and one year experience in examination, evaluation, and treatment of children with ASD *((Please provide an Employer letter, job description, resume, or other documentation)*
☐	Has extensive knowledge and training in behavior analysis defined as having documented course work at the graduate level at 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 *(Please provide transcript that documents successful completion)*
☐	Works under the supervision of a BCBA BCBA Name: _____ *(Please provide supervision documentation from BCBA if QBHP 2)*

MICHIGAN AUTISM PROGRAM

ASD-ABA Services Supervisor Staff Review- Qualified Licensed Practitioner

PIHP:	CMH/Provider:	Site Visit Date:
Primary WSA Case(s):	**Oversample WSA Case(s):**	**MDHHS Reviewer:**

18.3 Medicaid Provider Manual: Comprehensive diagnostic evaluations and re-evaluations are performed by a qualified licensed practitioner working within their scope of practice and who is qualified and experienced in diagnosing ASD. ***PLEASE NOTE: YOU MUST BE ABLE TO PROVIDE DOCUMENTED EVIDENCE DURING THE SITE REVIEW THAT SHOW PROVIDER MEETS THESE FEDERAL REQUIREMENTS.***

MDHHS VERIFIED	
	Qualified Licensed Practitioner (QLP) Name:_____ Employed by: _____
☐	Holds a current license in the State of Michigan *(Please provide a copy of license with license expiration date ____/_____/_____)*
☐	Is one of the following Qualified Licensed Practioners: ____1. a physician with a specialty in psychiatry or neurology; ____2. a physician with a sub-specialty in developmental pediatrics, developmental-behavioral pediatrics or a related discipline; ____3. a physician with a specialty in pediatrics: ____4. a psychologist (LP or LLP/TLLP); ____5. an advanced practice registered nurse; ____6. a physician assistant; ____7. a clinical social worker (Must indicate the practitioner is a Clinical MSW not Macro MSW)
☐	Has training, experience, or expertise in ASD and/or behavioral health *(Please provide an Employer letter, education/transcript, job description, resume, CV, or other documentation)*

MDHHS

MICHIGAN AUTISM PROGRAM

ASD-ABA Services Supervisor Staff Review- Qualified Licensed Practitioner

PIHP:	CMH/Provider:	Site Visit Date:
Primary WSA Case(s):	**Oversample WSA Case(s):**	**MDHHS Reviewer:**

18.3 Medicaid Provider Manual: Comprehensive diagnostic evaluations and re-evaluations are performed by a qualified licensed practitioner working within their scope of practice and who is qualified and experienced in diagnosing ASD. ***PLEASE NOTE: YOU MUST BE ABLE TO PROVIDE DOCUMENTED EVIDENCE DURING THE SITE REVIEW THAT SHOW PROVIDER MEETS THESE FEDERAL REQUIREMENTS.***

MDHHS VERIFIED	
	Qualified Licensed Practitioner (QLP) Name:_____
	Employed by: _____
☐	Holds a current license in the State of Michigan *(Please provide a copy of license with license expiration date ____/_____/_____)*
☐	Is one of the following Qualified Licensed Practitioners: ____1. a physician with a specialty in psychiatry or neurology; ____2. a physician with a sub-specialty in developmental pediatrics, developmental-behavioral pediatrics or a related discipline; ____3. a physician with a specialty in pediatrics: ____4. a psychologist (LP or LLP/TLLP); ____5. an advanced practice registered nurse; ____6. a physician assistant with training, experience, or expertise in ASD and/or behavioral health; ____7. a clinical social worker (Must indicate the practitioner is a Clinical MSW not Macro MSW),
☐	Has training, experience, or expertise in ASD and/or behavioral health *(Please provide an Employer letter, education/transcript, job description, resume, CV, or other documentation)*

MDHHS

Southwest Michigan
BEHAVIORAL HEALTH

ABA Authorization Review Instructions

Instructions:

1. The following information should be reviewed to assess the appropriateness and medical necessity of the amount, scope, and duration of ABA services:
    a. CMH Individual Plan of Service (IPOS), with detailed ABA treatment plan (may be an attachment, or directly included in the IPOS)
    b. Two most recent Behavioral Skills Assessment(s)
    c. Other information as needed to review medical necessity -
        i. Most recent Comprehensive Diagnostic Evaluation
        ii. Consultation with provider, case manager, supports coordinator, etc.
2. Partial or full denial of an ABA service request may only be made by a BCBA or QBHP who is not involved in the individual's treatment. To utilize SWMBH's contracted BCBA for consultation on ABA authorization requests, forward the BCBA Consultation Request form along with the documents listed under #2 above, to waivers@swmbh.org ***within 7 calendar days of the initial authorization request date***. A return disposition will be provided within 5 calendar days.

ABA Authorization Essential Elements. These requirements must be met with all ABA service authorization requests:

Eligibility for Michigan Medicaid Autism Benefit –

1. The child meets eligibility criteria for and is currently enrolled in the Michigan Medicaid Autism benefit.
2. The child remains eligible for Medicaid and is a State of Michigan resident.

Prevention of Duplication of Services and Medicaid Waste -

3. *ABA is not to be used to when other services such as respite, CLS, outpatient therapy, etc. would be effective to meet needs (in part or in whole). All ABA services requested and provided are for the purpose of direct delivery of ABA treatment* as identified in the treatment plan.
4. There is documentation that these services do not supplant special education and related services defined in the Individuals with Disabilities Education Act (IDEA) that are available to the child through a local education agency.

ABA Treatment Plan includes -

5. Specific skills and behaviors to be addressed, and their baseline/current frequency and/or duration.
6. The behavioral intervention techniques to address each skill and behavior (specific protocols must be available).
7. Measurable, objective long-term and short-term goals for these skills and behaviors.
8. Methods for training parents, guardians, and other caregivers.
9. Strategies for generalizing learned skills to multiple environments (may include parent training).
10. A discharge plan (indicators of being ready to discharge from ABA services).
11. Anticipated timelines for meeting the goals, fading, and discharge.

Southwest Michigan
BEHAVIORAL HEALTH

ABA Initial Authorization Review

Date		**WSA #:**	
Member Name		**CMH**	
Auth Request Date:		**Determination Date:**	

Both items should be marked YES for full continuing authorization. If either category is not met as YES, partial authorization may be approved to allow for plan/assessment updates and resubmission of authorization request. Any denials or partial approvals of ABA services must be made by a BCBA	**All criteria must be evaluated**	
1. Essential elements are met. **AND**	Yes	No
2. Hours per week requested are not more than what is required to achieve the objectives listed in the IPOS. **AND**	Yes	No

Explanation for any item marked "No":

Disposition:

Approved in full		**Approved in part***		**Denied***	
Consultation form attached (*required for partial approvals and denials)		**Yes**		**No**	

Comments:

UM Reviewer Name: _____

Signature/Credentials: _____ **Date:** _____

Southwest Michigan
BEHAVIORAL HEALTH

ABA Continuing Authorization Review

Date		**WSA #:**	
Member Name		**CMH**	
Auth Request Date:		**Determination Date:**	

Each item, 1-5, should be YES for full continuing authorization. **If #3 is NO, 3.a or 3.b must be YES. If #4 is NO, 4.a or 4.b must be YES.** If any category is not met as YES, partial authorization may be approved to allow for plan/assessment updates and resubmission of authorization request. Any denials or partial approvals of ABA services must be made by a BCBA	**All criteria must be evaluated**		
1. **Essential elements are still met.**	Yes	No	
2. **The child has not yet achieved ABA treatment goals.**	Yes	No	
3. **The frequency of the targeted behavior(s) has diminished, or there has there been improvement in the targeted skill(s).** *If NO, continue with a and b:*	Yes	No	
a. If the answer to #3 is No, have additional assessments and consultations been conducted, and the treatment plan modified? (consultation from other staff and professionals, interventions changed, and parents retrained on the changed approaches). ***If Yes, continue to 3.b. If No, treatment plan must be updated, prior to continuing authorization for services. Partial (typically 30-day) authorization may be approved to allow for plan/assessment updates and resubmission of authorization request.***	*Yes*	*No*	*N/A*
b. If for 180 days, there is a continued absence of adequate improvement, has the treatment plan been revised to reflect a planned discontinuation of ABA, and referral to other non-ABA resources as appropriate? ***If changes/updates to plan have been in place less than 180 days, select N/A.***	*Yes*	*No*	*N/A*
4. **The child and/or parent/guardian are able to meaningfully participate in the ABA services (e.g., attendance at 75% or more of planned sessions per IPOS), and to follow through with treatment recommendations.** *If NO, continue with a and b:*	Yes	No	
a. If the answer to #4 is No, has ABA treatment provider and/or SC/TCM addressed concerns with the child and family, and implemented measures to support meaningful participation (transportation assistance, adjustments to treatment schedule, additional family training and support, etc.)? ***If Yes, continue to 4.b. If No, treatment plan must be updated, prior to continuing authorization for services. Partial authorization (typically 30-day) may be approved to allow for plan/assessment updates and resubmission of authorization request.***	*Yes*	*No*	*N/A*
b. If for 180 days, there is a continued lack of family engagement, to a degree that compromises the potential effectiveness and outcome of the ABA service, has the treatment plan been revised to reflect a planned discontinuation of ABA, and referral to other non-ABA resources as appropriate? ***If changes/updates to plan have been in place less than 180 days, select N/A.***	*Yes*	*No*	*N/A*
5. **Hours per week requested are not more than what is required to achieve the objectives listed in the IPOS.**	Yes	No	

Southwest Michigan
BEHAVIORAL HEALTH

ABA Continuing Authorization Review, cont.

Explanation for any item marked "No":

Disposition:

Approved in full		Approved in part*		Denied*			
Consultation form attached (*required for partial approvals and denials)				Yes		No	

Comments:

UM Reviewer Name: _____

Signature/Credentials: _____ Date: _____

Southwest Michigan
BEHAVIORAL HEALTH

BCBA Consultation Form

Instructions:

1. To utilize SWMBH's contracted BCBA for consultation on ABA authorization requests, securely email this form along with the documents listed under Section V below, to waivers@swmbh.org ***within 7 calendar days of the initial authorization request date***. A return disposition will be provided by email within 5 calendar days.
2. Once the authorization determination has been made, email the ABA Initial (or Continuing) Authorization Review Form with the IPOS, IPOS Upload Request Form, and consultation form, to waivers@swmbh.org. The IPOS will be uploaded by SWMBH to the WSA for MDHHS and PIHP approval.

Part 1, to be completed by the CMH:

I. Demographic Information			
Today's Date		**WSA #**	
Member Name		**CMH**	
II. Consultation Type			
☐ **Initial ABA Auth Review**	☐ **Continuing ABA Auth Review**	☐ **Other (describe below)**	
Description of other consultation need:			
Authorization Request Date:		**Determination Due Date:**	
III. CMH Contact Information			
Name of CMH Employee Making Request			
Email		**Phone**	
IV. ABA Provider Contact Information			
Name of ABA Supervisor		**Email**	
ABA Provider Org			
V. Background Information			

Documents Attached (all are required except "other"):

- ☐ Individual Plan of Service (IPOS)
- ☐ Behavioral Skills Assessment – 2 most recent if applicable
- ☐ Comprehensive Diagnostic Evaluation
- ☐ Psychosocial Assessment
- ☐ Other (describe):

Considerations (check all that apply):

- ☐ Lack of progress in skill development or target behavior reduction
- ☐ Concerns with family or child's participation in treatment
- ☐ Planned objectives do not support number of ABA hours
- ☐ Special education and Medicaid service overlap
- ☐ Less intensive services may be appropriate to meet needs
- ☐ Treatment plan missing essential elements
- ☐ Other (describe):

Summary of Consultation Request:

Southwest Michigan
BEHAVIORAL HEALTH

BCBA Consultation Form, cont.

Part 2, to be completed by BCBA:

Today's Date		WSA #	
Member Name		CMH	

Findings and Recommended Course of Action:

Disposition:

Approved in full		Approved in part		Denied	

Service	Dates Approved	Units Approved	Dates Denied	Units Denied

Reviewed by (Name):

Signature/Credentials: _____ Date: _____