

**SERVICE DESCRIPTION****Behavioral Health Treatment Services/Applied Behavior Analysis (ABA)**

*This service must be provided consistent with requirements outlined in the MDHHS Medicaid Provider Manual as updated. The manual is available at:*

<http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>

**1. Definition or Description of Service**

- a. The purpose of this policy is to provide for the coverage of Behavioral Health Treatment (BHT) services, including Applied Behavior Analysis (ABA), for children under 21 years of age with Autism Spectrum Disorders (ASD). All children, including children with ASD, must receive EPSDT services that are designed to assure that children receive early detection and preventive care, in addition to medically necessary treatment services to correct or ameliorate any physical or behavioral conditions, so that health problems are averted or diagnosed and treated as early as possible.
- b. According to the U.S. Department of Health & Human Services (HHS), autism is characterized by impaired social interactions, problems with verbal and nonverbal communication, repetitive behaviors, and/or severely limited activities and interests. Early detection and treatment can have a significant impact on the child's development. Autism can be viewed as a continuum or spectrum, known as Autism Spectrum Disorder (ASD), and includes Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder - Not Otherwise Specified (PDD-NOS). The disorders on the spectrum vary in severity and presentation, but have certain common core symptoms. The goals of treatment for ASD focus on improving core deficits in communication, social interactions, and restricted behaviors. Changing these fundamental deficits may benefit children by developing greater functional skills and independence.
- c. BHT services prevent the progression of ASD, prolong life, and promote the physical and mental health and efficiency of the child. Medical necessity and recommendation for BHT services is determined by a physician, or other licensed practitioner working within their scope of practice under state law. Direct patient care services that treat or address ASD under the state plan are available to children under 21 years of age as required by the EPSDT benefit.
- d. Screening
  - i. The American Academy of Pediatrics (AAP) endorses early identification of developmental disorders as being essential to the well-being of children and their families. Early identification of developmental disorders through screening by health care professionals should lead to further evaluation, diagnosis, and treatment. Early identification of a developmental disorder's underlying etiology may affect the medical treatment of the child and the parent's/guardian's intervention planning. Screening for ASD typically occurs during an EPSDT well child visit with the child's primary care provider (PCP). EPSDT well child visits may include a review of the child's overall medical and physical health, hearing, speech, vision, behavioral and developmental status, and screening for ASD with a validated and standardized screening tool. The EPSDT well child evaluation is also designed to rule out medical or behavioral conditions other than ASD, and include those conditions that may have behavioral implications and/or may co-occur with ASD. A full medical and physical examination must be performed before the child is referred for further evaluation.
- e. Referral
  - i. The PCP who screened the child for ASD and determined a referral for further evaluation was necessary will contact the Pre-Paid Inpatient Health Plan (PIHP)

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

- ii. After a beneficiary is screened and the PCP determines a referral is necessary for a follow-up visit, the PIHP is responsible for the comprehensive diagnostic evaluation, behavioral assessment, BHT services (including ABA) for eligible Medicaid beneficiaries, and for the related EPSDT medically necessary Mental Health Specialty Services. Occupational therapy, physical therapy, and speech therapy for children with ASD who do not meet the eligibility requirements for developmental disabilities by the PIHP are covered by the Medicaid Health Plan or by Medicaid Fee-for-Service.
- f. Comprehensive Diagnostic Evaluations
- i. Accurate and early diagnosis of ASD is critical in ensuring appropriate intervention and positive outcomes. The comprehensive diagnostic evaluation must be performed before the child receives BHT services. The comprehensive diagnostic evaluation is a neurodevelopmental review of cognitive, behavioral, emotional, adaptive, and social functioning, and should include validated evaluation tools. Based on the evaluation, the practitioner determines the child's diagnosis, recommends general ASD treatment interventions, and refers the child for a behavior assessment which is provided or supervised by a BCBA to recommend more specific ASD treatment interventions. The diagnostic evaluations are performed by a qualified licensed practitioner working within their scope of practice and who is qualified and experienced in diagnosing ASD. A qualified licensed practitioner includes:
    - (a) a physician with a specialty in psychiatry or neurology;
    - (b) a physician with a subspecialty in developmental pediatrics, developmental-behavioral pediatrics or a related discipline;
    - (c) a physician with a specialty in pediatrics or other appropriate specialty with training, experience or expertise in ASD and/or behavioral health;
    - (d) a psychologist;
    - (e) an advanced practice registered nurse with training, experience, or expertise in ASD and/or behavioral health;
    - (f) a physician assistant with training, experience, or expertise in ASD and/or behavioral health; or
    - (g) a clinical social worker, working within their scope of practice, and is qualified and experienced in diagnosing ASD.
  - ii. The determination of a diagnosis by a qualified licensed practitioner 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:

- (a) 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);
- (b) 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
- (c) symptom monitoring, such as Social Responsiveness Scale-II (SRS-II), Aberrant Behavior Checklist, or Social Communication Questionnaire (SCQ).

**2. Credentialing Requirements** *Refer to current Medicaid Provider Manual for updated requirements*

- a. BHT 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. BHT services must be provided under the direction of a BCBA, another appropriately qualified LP or LLP, or a Master's prepared QBHP. These services must be provided directly to, or on behalf of, the child by training their parents/guardians, behavior technicians, and BCaBAs to deliver the behavioral interventions. The BCBA and other qualified providers are also responsible for communicating progress on goals to the parents/guardians minimally every three to six months; clinical skill development and supervision of the BCaBA, QBHP and behavior technicians; and collaborating with support coordinators/case managers and the parents/guardians on goals and objectives with participation in development of the IPOS that includes the behavioral plan of care.
- b. Board Certified Behavior Analyst – Doctoral (BCBA-D) or Board Certified Behavior Analyst (BCBA)
  - i. Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction.
  - ii. License/Certification: Current certification as a BCBA through the BACB. The BACB is the national entity accredited by the National Commission for Certifying Agencies (NCCA).
  - iii. Education and Training: Minimum of a master's degree from an accredited institution conferred in a degree program in which the candidate completed a BACB approved course sequence.
- c. Licensed Psychologist (LP)
  - i. Must be certified as a BCBA by September 30, 2025.
  - ii. Service Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction.
  - iii. License/Certification: LP means a doctoral level psychologist licensed by the State of Michigan. Must complete all coursework and experience requirements.
  - iv. Education and Training: Minimum doctorate degree from an accredited institution. Works within their scope of practice and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented coursework at the graduate level from an accredited university in at least three of the six following areas:
    - (a) Ethical considerations
    - (b) Definitions and characteristics; and principles, processes and concepts of behavior
    - (c) Behavioral assessment and selecting interventions outcomes and strategies.
    - (d) Experimental evaluation of interventions.

- (e) Measurement of behavior, and developing and interpreting behavioral data.
    - (f) Behavioral change procedures and systems supports.
  - v. A minimum of one year experience in treating children with ASD based on the principles of behavior analysis. Works in consultation with the BCBA to discuss the caseload, progress, and treatment of the child with ASD.
- d. Limited License Psychologist (LLP)
  - i. Must be certified as a BCBA by September 30, 2025.
  - ii. Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction.
  - iii. License/Certification: LLP means a doctoral or master level psychologist licensed by the State of Michigan. Limited psychologist master's limited license is good for one two (2)-year period. Must complete all coursework and experience requirements.
  - iv. Education and Training: Minimum of a master's or doctorate degree from an accredited institution. Works within their scope of practice and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented coursework at the graduate level from an accredited university in at least three of the six following areas:
    - (1) Ethical considerations
    - (2) Definitions, characteristics, principles, processes, and concepts of behavior
    - (3) Behavioral assessment, 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
  - v. A minimum of one year experience in treating children with ASD based on the principles of behavior analysis. Works in consultation with the BCBA to discuss the progress and treatment of the child with ASD.
- e. Board Certified Assistant Behavior Analyst (BCaBA)
  - i. Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction.
  - ii. License/Certification: Current certification as a BCaBA through the BACB. The BACB is the national entity accredited by the NCCA.
  - iii. Education and Training: Minimum of a bachelor's degree from an accredited institution conferred in a degree program in which the candidate completed a BACB approved course sequence.
  - iv. Other Standard: Works under the supervision of the BCBA.
- f. Qualified Behavioral Health Professional (QBHP)
  - i. Must be certified as a BCBA by September 30, 2025.
  - ii. Must be certified as a BCBA within two years of successfully completing their applied behavior analysis (ABA) graduate coursework.
  - iii. Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction.
  - iv. License/Certification: A license or certification is not required, but is optional.
  - v. Education and Training: 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) Minimum of a master's degree in a mental health-related field or BACB approved degree category from an accredited institution with specialized training and one year of experience in the examination, evaluation, and treatment of children with ASD. Works within their scope of practice, works under the supervision of the BCBA, and has extensive knowledge and training

in behavior analysis. Extensive knowledge is defined as having received documented coursework at the graduate level from an accredited university in at least three of the six following areas:

- (a) Ethical considerations.
- (b) Definitions and characteristics; and principles, processes and concepts of behavior.
- (c) Behavioral assessment and selecting interventions outcomes and strategies.
- (d) Experimental evaluation of interventions.
- (e) Measurement of behavior and developing and interpreting behavioral data.
- (f) Behavioral change procedures and systems supports.

**g. Behavior Technician**

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

**3. Service Requirements – BHT Services**

**a. Behavioral Assessment**

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

**b. Behavioral Intervention**

BHT services include a variety of behavioral interventions which have been identified as evidence-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence. BHT services are designed to be delivered primarily in the home and in other community settings. Behavioral intervention services include, but are not limited to, the following categories of evidence-based interventions:

- i. Collecting information systematically regarding behaviors, environments, and task demands (e.g., shaping, demand fading, task analysis);

- ii. Adapting environments to promote positive behaviors and learning while discouraging negative behaviors (e.g., naturalistic intervention, antecedent based intervention, visual supports, stimulus fading);
  - iii. Applying reinforcement to change behaviors and promote learning (e.g., reinforcement, differential reinforcement of alternative behaviors, extinction);
  - iv. Teaching techniques to promote positive behaviors, build motivation, and develop social, communication, and adaptive skills (e.g., discrete trial teaching, modeling, social skills instruction, picture exchange communication systems, pivotal response training, social narratives, self-management, prompting, chaining, imitation);
  - v. Teaching parents/guardians to provide individualized interventions for their child for the benefit of the child (e.g., parent/guardian implemented/mediated intervention);
  - vi. Using typically developing peers (e.g., Individuals who do not have ASD) to teach and interact with children with ASD (e.g., peer mediated instruction, structured play groups, peer social interaction training); and
  - vii. Applying technological tools to change behaviors and teach skills (e.g., video modeling, tablet-based learning software).
  - viii. In addition to the above listed categories of interventions, covered BHT treatment services may also include any other intervention supported by credible scientific and/or clinical evidence, as appropriate for each Individual. Based on the behavioral plan of care which is adjusted over time based on data collected by the qualified provider to maximize the effectiveness of BHT treatment services, the provider selects and adapts one or more of these services, as appropriate for each Individual.
- c. Behavioral Observation and Direction
- Behavioral observation and direction is the clinical direction and oversight provided by a qualified provider to a lower level provider based on the required provider standards and qualifications regarding the provision of services to a child. The qualified provider delivers face-to-face observation and direction to a lower level provider regarding developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for each child. This service is for the direct benefit of the child and provides a real-time response to the intervention to maximize the benefit for the child. It also informs of any modifications needed to the methods to be implemented to support the accomplishment of outcomes in the behavioral plan of care.
- d. Telepractice for BHT Services
- i. All telepractice services must be prior authorized (i.e., IPOS indicates telepractice as an identified treatment modality for the Individual) by the Michigan Department of Health and Human Services (MDHHS). Telepractice is the use of telecommunications and information technologies for the exchange of encrypted patient data for the provision of services (e.g. access or travel to needed medical services may be prohibitive). Telepractice must be obtained through real-time interaction between the child's physical location (patient site) and the provider's physical location (provider site). Telepractice services are provided to patients through hardwire or internet connection. It is the expectation that providers, facilitators, and staff involved in telepractice are trained in the use of equipment and software prior to servicing patients. Qualified providers of behavioral health services are able to arrange telepractice services for the purposes of teaching the parents/guardians to provide individualized interventions to their child and to engage in behavioral health clinical observation and direction (i.e., increase oversight of the provision of services to the Individual to support the outcomes of the behavioral plan of care developed by the primary supervising BHT provider). Qualified providers of behavioral health services include Board Certified Behavior Analysts (BCBA), Board Certified Assistant Behavior

Analysts (BCaBA), Licensed Psychologists (LP), Limited Licensed Psychologists (LLP), and Qualified Behavioral Health Professionals (QBHP). The provider of the telepractice service is only able to monitor one child/family at a time. The administration of telepractice services are subject to the same provision of services that are provided to a patient in person. Providers of telepractice services must be currently certified by the Behavior Analyst Certification Board (BACB), be a QBHP enrolled in a BACB degree program, be licensed in the State of Michigan as a fully licensed psychologist, or be a practitioner who holds a limited license and is under the direction of a fully licensed psychologist. Providers must ensure the privacy of the child and secure any information shared via telemedicine.

- ii. The technology used must meet the requirements of audio and visual compliance in accordance with current regulations and industry standards. Refer to the General Information for Providers Chapter of this manual for the complete Health Insurance Portability and Accountability Act (HIPAA) compliance requirements.
  - iii. The patient site may be located within a center, clinic, at the patient's home, or any other established site deemed appropriate by the provider. The room must be free from distractions that would interfere with the telepractice session. A facilitator must be trained in the use of the telepractice technology and be physically present at the patient site during the entire telepractice session to assist the patient at the direction of the qualified provider of behavioral health. Occupational, physical, and speech therapy are not covered under telepractice services. Refer to the Telemedicine Services database on the MDHHS website for appropriate or allowed telemedicine services that may be covered by the Medicaid Health Plan or by Medicaid Fee-for-Service. (Refer to the Directory Appendix for website information.)
- e. BHT Service Level
- i. BHT services are available for Medicaid beneficiaries diagnosed with ASD and are provided for all levels of severity of ASD. The behavioral intervention should be provided at an appropriate level of intensity in an appropriate setting(s) within their community for an appropriate period of time, depending on the needs of the child and their parents/guardians. Clinical determinations of service intensity, setting(s), and duration are designed to facilitate the child's goal attainment. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings, but are not intended to supplant services provided in school or other settings, or to be provided when the 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 recommended service level, setting(s), and duration 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. The service level includes the number of hours of intervention provided to the child. The service level determination will be based on research-based interventions integrated into the behavioral plan of care with input from the planning team. Service intensity will vary with each child and should reflect the goals of treatment, specific needs of the child, and response to treatment. The PIHP's Utilization Management will authorize the level of services prior to the delivery of services.
  - ii. 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).

- iii. **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).
- f. **BHT Service Evaluation**
- i. As part of the IPOS, there is a comprehensive, individualized behavioral plan of care that includes specific targeted behaviors, along with measurable, achievable, and realistic goals for improvement. BCBA and other qualified providers develop, monitor, and implement the behavioral plan of care. These providers are responsible for effectively evaluating the child's response to treatment and skill acquisition. Ongoing determination of the level of service (minimally every six months) requires evidence of measurable and ongoing improvement in targeted behaviors that are demonstrated with the use of reliable and valid assessment instruments (i.e., VB-MAPP, ABLLS-R, AFLS) and other appropriate documentation of analysis (i.e., graphs, assessment reports, records of service, progress reports, etc.).
  - ii. The Provider shall ensure coordination of care occurs between the Individual(s) primary health care physician and Medicaid Health Plan, as appropriate. Coordination of care shall include the full array of primary and acute physical health services, behavioral health care, natural or community supports to provide effective treatment and as specified in an Individual's plan of service.
  - iii. The Provider shall ensure language interpretation, translation services, and hearing interpreter services are provided as needed.
- g. The Provider shall complete services documentation and records that meet the CMHSP's requirements for reimbursement. The Provider's services and documentation/records shall comply with the standards of the CMHSP, accreditation bodies, MDHHS, any applicable licensing Department or Agency of the State of Michigan, Medicaid and Medicare regulations and/or any third party payers.
- h. The Individual's record must contain sufficient information to document the provision of services, including the nature of the service, the date, and the location of contacts, including whether the contacts were face-to-face. The frequency and scope of contacts must take into consideration the health and safety needs of the Individual.

#### **4. Training Requirements**

- a. See Attachment I: Training Requirements for specific training requirements and frequency of trainings.
- b. Provider will ensure and document that each staff is trained on the Individual's IPOS and ancillary plans, prior to delivery of service.

#### **5. Eligibility Criteria/Access Requirements/Authorization Procedures**

- a. **Medical Necessity Criteria**
  - i. Medical necessity and recommendation for BHT services is determined by a physician or other licensed practitioner working within their scope of practice under state law. The child must demonstrate substantial functional impairment in social communication, patterns of behavior, and social interaction as evidenced by meeting criteria A and B (listed below); and require BHT services to address the following areas:
    - (1) The child currently demonstrates substantial functional impairment in social communication and social interaction across multiple contexts, and is manifested by all of the following:



- (a) Deficits in social-emotional reciprocity ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation, to reducing sharing of interests, emotions, or affect, to failure to initiate or respond to social interactions.
    - (b) Deficits in nonverbal communicative behaviors used for social interaction ranging, for example from poorly integrated verbal and nonverbal communication, to abnormalities in eye contact and body language or deficits in understanding and use of gestures, to a total lack of facial expressions and nonverbal communication.
    - (c) Deficits in developing, maintaining, and understanding relationships ranging, for example, from difficulties adjusting behavior to suit various social contexts, to difficulties in sharing imaginative play or in making friends, to absence of interest in peers.
  - (2) The child currently demonstrates substantial restricted, repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least two of the following:
    - (a) Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, and/or idiosyncratic phrases).
    - (b) Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, and/or need to take same route or eat the same food every day).
    - (c) Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects and/or excessively circumscribed or perseverative interest).
    - (d) Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, and/or visual fascination with lights or movement).
- b. Determination of Eligibility for BHT
  - i. The following is the process for determining eligibility for BHT services for a child with a confirmed diagnosis of ASD. Eligibility determination and recommendation for BHT must be performed by a qualified licensed practitioner through direct observation utilizing the ADOS-2 and symptom rating using the DD-CGAS. BHT services are available for children under 21 years of age with a diagnosis of ASD from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), and who have the developmental capacity to clinically participate in the available interventions covered by BHT services. A well-established DSM-IV diagnosis of Autistic Disorder, Asperger's Disorder or PDD-NOS should be given the diagnosis of ASD. Children who have marked deficits in social communication but whose symptoms do not otherwise meet criteria for ASD should be evaluated for social (pragmatic) communication disorder.
    - (1) The following requirements must be met:
      - (a) Child is under 21 years of age.

- (b) Child received a diagnosis of ASD from a qualified licensed practitioner utilizing valid evaluation tools.
  - (c) Child is medically able to benefit from the BHT treatment.
  - (d) Treatment outcomes are expected to result in a generalization of adaptive behaviors across different settings to maintain the BHT interventions and that they can be demonstrated beyond the treatment sessions. Measurable variables may include increased social-communication, increased interactive play/age-appropriate leisure skills, increased reciprocal communication, etc.
  - (e) Coordination with the school and/or early intervention program is critical. Collaboration between school and community providers is needed to coordinate treatment and to prevent duplication of services. This collaboration may take the form of phone calls, written communication logs, participation in team meetings (i.e., Individual Education Plan/Individual Family Service Plan [IEP/IFSP], Individual Plan of Service [IPOS], etc.).
  - (f) Services are able to be provided in the child's home and community, including centers and clinics.
  - (g) Symptoms are present in the early developmental period (symptoms may not fully manifest until social demands exceed limited capacities, or may be masked by learned strategies later in life).
  - (h) Symptoms cause clinically significant impairment in social, occupational, and/or other important areas of current functioning that are fundamental to maintain health, social inclusion, and increased independence.
  - (i) A qualified licensed practitioner recommends BHT services and the services are medically necessary for the child.
  - (j) Services must be based on the individual child and the parent's/guardian's needs and must consider the child's age, school attendance requirement, and other daily activities as documented in the IPOS. Families of minor children are expected to provide a minimum of eight hours of care per day on average throughout the month.
- c. Prior Authorization
- i. BHT services are authorized for a time period not to exceed 365 days. The 365-day authorization period for services may be re-authorized annually based on recommendation of medical necessity by a qualified licensed practitioner working within their scope of practice under state law.
- d. Re-evaluation
- i. An annual re-evaluation by a qualified licensed practitioner to assess eligibility criteria must be conducted through direct observation utilizing the ADOS-2 and symptoms rated using the DD-CGAS. Additional tools should be used if the clinician feels it is necessary to determine medical necessity and recommended services. Other tools may include cognitive/developmental tests, adaptive behavior tests, and/or symptom monitoring.
- e. Discharge Criteria
- i. Discharge from BHT services is determined by a qualified BHT professional for children who meet any of the following criteria:

- (1) The child has achieved treatment goals and less intensive modes of services are medically necessary and appropriate.
  - (2) The child is either no longer eligible for Medicaid or is no longer a State of Michigan resident.
  - (3) The child has not demonstrated measurable improvement and progress toward goals, and the predicted outcomes as evidenced by a lack of generalization of adaptive behaviors across different settings where the benefits of the BHT interventions are not able to be maintained or they are not replicable beyond the BHT treatment sessions through a period of six months.
  - (4) Targeted behaviors and symptoms are becoming persistently worse with BHT treatment over time or with successive authorizations.
  - (5) The child no longer meets the eligibility criteria as evidenced by use of valid evaluation tools administered by a qualified licensed practitioner.
  - (6) The child and/or parent/guardian is not able to meaningfully participate in the BHT services, and does not follow through with treatment recommendations to a degree that compromises the potential effectiveness and outcome of the BHT service.
- f. The [PIHP Guide to Services](#) provides a summary of service eligibility, access to services, and service authorization. Additional information related to policies, procedures and Provider Manuals may be found by accessing the specific CMHSP websites.