Comprehensive Autism Care Demonstration

# Clinical Necessity Reviews

Health Net Federal Services, LLC (HNFS) is required to perform clinical necessity reviews on all treatment plans before making coverage determinations for applied behavior analysis (ABA) services. Clinical necessity reviews, performed by qualified clinical reviewers (BCBAs, BCBA-Ds), follow a standardized approach that considers the individual beneficiary to ensure the treatment plan coincides with the most appropriate level of care.

Clinical necessity reviews include the evaluation of:

- Treatment plan documents
- Individualized Education Programs (IEP), if applicable
- The following outcome measures:
  - Pervasive Developmental Disorder Behavior Inventory (PDDBI)
  - Vineland, 3rd Edition (Vineland-3)
  - Social Responsiveness Scale, Second Edition (SRS-2)

## Overarching Areas Considered for Clinical Necessity

- Level of clinical support/need:
  - Autism spectrum disorder (ASD) diagnostic severity
  - Maladaptive behaviors related to ASD
  - Outcome measure scores
- Treatment plan
  - Presentation of symptoms
  - Goal selection
  - Use of outcome measure scores
  - Descriptions of progress and modifications
  - Use of evidenced based treatments
- Dose response (intensity, frequency, duration)/duration of services
  - Current request for authorized units
  - Corresponding level of symptom improvement
  - Current and longitudinal appropriateness for current symptomology
  - Recommended vs. requested for authorization vs rendered hours
  - Context of length of time in ABA treatment
- Progress towards improved symptom presentation
  - Analysis of outcome measures
  - Analysis of treatment plan goals
  - Analysis of targeted maladaptive behaviors
- Other rendered services

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- The overall treatment necessity, including symptoms effectively treated by other specialties
- Analysis of co-morbid diagnosis and symptoms
- Review of any non-ASD related treatment plan goals
- Review of other treatments being accessed

- Parent engagement focuses on the analysis of:
  - Parent participation levels
  - Parent/caregiver goals and goal progress
  - Planning and preparedness of parent generalization and maintenance outside of active service delivery

# Clinical Consultation and Provider Engagement

Following the clinical necessity review, the BCBA clinical reviewer will either:

- Make a coverage determination.
- Request additional information.
- Schedule a clinical consultation with the responsible ABA supervisor.

## Clinical Consultations

The clinical consultation will address areas of concern and sections in the treatment plan that need to be addressed and resubmitted prior to treatment authorization. The consultation may address:

- Missing documentation
- Exclusions
- Stagnation or regression on goals or outcome measures
- Lack of parent engagement and goal progress
- Barriers to compliance with program requirements
- Lack of clinical necessity for ABA services
- Discharge recommendations

Required changes to the treatment plan may include additional explanations, new or modified goals, and references to outcome measures or items related to clinical necessity and parent engagement.

Following the consultation, the ABA supervisor will receive a written communication outlining the changes required (the changes that were discussed during the consultation) and include instruction for the resubmission of the request for authorization. Once the ABA supervisor resubmits the treatment plan, a second review ensures compliance with program requirements prior to a coverage determination. If the resubmitted treatment plan fails to address all changes and/or demonstrate clinical necessity, an additional consultation may be required between the ABA supervisor and the clinical reviewer.

If the ABA supervisor is unwilling to update the treatment plan, the coverage determination may result in a full denial or partial denial.

Providers can avoid or minimize requests for clinical consultation by:

- Adhering to treatment plan requirements.
- Meeting expectations on progress and summaries.
- Developing clear and objective goals and treatment paths; and
- Addressing areas of concern clearly (e.g., outcome measure regression, goals progress, etc.) with full explanations and treatment alterations.

## Use of PSI-4/SIPA Scores

HNFS' clinical reviewers do not use submitted Parenting Stress Index, Fourth Edition (PSI-4) and Stress Index for Parents of Adolescents (SIPA) scores when making coverage determinations. However, after a coverage determination has been rendered, clinical reviewers will use PSI-4/SIPA scores to identify whether additional family support would be beneficial to increase parent engagement, decrease familial stress and/or support the beneficiary's access to services. Clinical reviewers may engage with families about additional support, as appropriate.

# Processing Timelines

- HNFS will complete an administrative review of the request for authorization within two to five business days of receipt by the ABA provider. The administrative review includes:
  - Verification of eligibility
  - Verification ACD program requirements are met
  - Verification of a valid referral
  - Verification of a comprehensive care plan (beneficiaries with Autism Services Navigators only)
  - Verification of a complete and valid PDDBI (parent form/teacher form, as applicable)
  - Verification of a complete and valid Vineland-3, SRS-2 and PSI-4/SIPA
  - Verification of minimum treatment plan requirements (i.e., location of services)
- HNFS will complete the clinical necessity review within five business days of the verification of administrative requirement compliance.
- If there are no changes to the treatment plan, HNFS will complete a coverage determination and send correspondence by the fifth business day.
- If a provider consultation is required, HNFS will attempt to contact the treating ABA supervisor by the fifth business day. If no contact is made, an alternative appointment date and time will be offered to the treating ABA supervisor, with the provider consultation targeted to occur no greater than 10 business days. HNFS will cancel the request for authorization if the consultation is not completed within 10 business days. The treating ABA supervisor will need to complete the consultation and resubmit the treatment plan and/or additional information for a second review for coverage determination.
- If additional information is required, HNFS will notify the treating ABA supervisor, either via letter correspondence or during the provider consultation, that modifications to the treatment plan must be completed. The ABA supervisor has up to 10 business days to resubmit the treatment plan with modifications. Once received, HNFS will complete the clinical necessity review on the now complete treatment plan within five business days for a coverage determination.
- Responding to requests for consultation and/or additional information in a timely manner is the ABA supervisor's responsibility and helps to prevent potential gaps in care. HNFS will not issue any backdated or retro authorizations under any circumstances. The treating ABA provider is encouraged to submit the request for reauthorization up to 60 days in advance to allow for the review process, consultation process and re-review, if necessary.

# Definition and Guidelines

- **Treatment plan:** A written document outlining the ABA supervisor's plan of care for TRICARE beneficiaries receiving ABA services.
- **Requests for authorization submission process:** Submit all requests for authorization of care to HNFS using our online authorization submission tools at **www.tricare-west.com** > *I'm a Provider* > *Submit an Authorization.*
- **Requests for reauthorization:** If continued services are clinically indicated, prior to the expiration of each six-month treatment authorization period (as early as 60 calendar days in advance but no later than 30 calendar days in advance), the ABA provider must submit a reauthorization for ABA services.
- **Late reauthorization requests:** ABA providers who submit reauthorization requests less than 30 calendar days from the expiration date of the current authorization are at risk for non-payment, should the existing authorization expire before HNFS approves the renewal request.
- **Clinical necessity review:** All treatment requests are reviewed for clinical necessity prior to authorization and may include requests for additional information, clinical consultation and/or required alterations to treatment plans.