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Owner	Rachel Barnhart: ASD BenefitProgram Administrator
Policy Area	Children Services

Autism Benefit Policy

POLICY

To provide guidance to Detroit Wayne Integrated Health Network's (DWIHN) provider network for coverage of the Behavioral Health Treatment (BHT) services for Applied Behavior Analysis (ABA). It is the policy of DWIHN that our service providers utilize established practices, as approved by the Michigan Department of Health and Human Services (MDHHS), or as endorsed or mandated by DWIHN.

PURPOSE

The purpose of this policy is to ensure that enrollees/members receiving BHT services with DWIHN receive effective treatment. This treatment should be evidence-based, and/or accepted best practices, and/or mandated/endorsed by MDHHS and DWIHN.

APPLICATION

1. **The following groups are required to implement and adhere to this policy: DWIHN Board, DWIHN Staff, Contractual Staff, Clinically Responsible Service Provider (CRSP) and their subcontractors, Specialty Providers and their subcontractors.**
2. **This policy serves the following populations: Adults, Children, Individuals with Intellectual and/or Developmental Disabilities (I/DD), Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), Autism**
3. **This policy impacts the following contracts/service lines: MI-HEALTH LINK, Medicaid, SUD, Autism, Grants, General Fund**

KEYWORDS

1. Autism Spectrum Disorder (ASD)
2. Evidence-Based Practice (EBP)
3. Best Practice Guidelines
4. Behavioral Health Treatment (BHT)
5. Applied Behavioral Analysis (ABA)
6. Behavior Analyst (BA)
7. Board Certified Behavior Analyst-Doctoral (BCBA-D)
8. Board Certified Behavior Analyst (BCBA)
9. Board Certified Assistant Behavior Analyst (BCaBA)
10. Qualified Behavioral Health Professional (QBHP)
11. Registered Behavior Technician (RBT)
12. Behavior Technician (BT)
13. Clinically Responsible Service Provider (CRSP)
14. Coordination of Care
15. Individual Plan of Service (IPOS)
16. Support Coordination (SC)
17. Case Management (CM)
18. Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT):
19. Family-Driven
20. Center-Based Services
21. Home-Based Services
22. Referral
23. ASD Screening Tool
24. Independent Evaluator
25. Comprehensive Diagnostic Evaluation
26. Medical Necessity
27. Re-Evaluation
28. Transition
29. Discharge
30. Behavioral Assessment
31. Behavior Intervention
32. Behavioral Observation and Direction
33. Behavioral Assessment Review

34. Service Level of Care (LOC)
35. Intellectual and Developmentally Delayed (I/DD)
36. Serious Emotional Disturbance (SED)

STANDARDS

1. **General**
    a. The Autism Benefit is a benefit under the Behavioral Health Treatment Services (BHT) which provides access to evidence-based Applied Behavior Analysis (ABA) Services to individuals covered by Medicaid ages birth to twenty-one with an autism spectrum disorder (ASD) diagnosis. The Medicaid Autism Benefit covers Comprehensive Diagnostic Evaluations, Psychological Testing, Adaptive Testing, Behavior Assessments, Behavior Plans of Care, ABA Direct Services, Technician Direction and Observation (Supervision), group training and Parent/Guardian Training. Individuals receiving the Autism Benefit have access to other services deemed medically necessary that are covered by Medicaid and provided by DWIHN.
    b. DWIHN is the initial point of access for members who have been referred and require a screening to be completed for a comprehensive diagnostic evaluation and behavioral assessment of ASD. DWIHN is responsible for scheduling the comprehensive diagnostic evaluation, behavioral assessment, and assisting with connection to BHT services (including ABA) for eligible Medicaid beneficiaries. Refer to the **Eligibility and Screening Policy** for additional information.
    c. The DWIHN Access Call Center provides information on an array of services and supports for eligible persons with serious mental illness, serious emotional disturbance, substance use disorders, and/or intellectual/developmental disabilities. There is no "wrong door" for access to people with any of these disorders.

2. **Record Retention (MPM 14.1)**
    a. Providers must maintain an electronic medical record that is necessary to fully disclose and document the extent of services provided to beneficiaries. Refer to Record Retention and Disposal Policy for additional information.
    b. All Incident Reports are used for documentation purposes for review by the recipient rights advisor/officer. The advisor/officer will determine if a possible rights violation has occurred, and if the incident needs to be further investigated. Refer to Incident Reporting Policy for additional information.
3. **Target Service Group**
    a. The target group for the ASD benefit includes individuals from birth and up to twenty-one (21) years of age, with a diagnosis of Autism Spectrum Disorder (ASD).
4. **Screening for Autism Spectrum Disorder (MPM 6.2, 18.1)**
    a. Early identification of developmental disorders through screening by Primary Care Provider (PCP) should lead to further evaluation, diagnosis, and treatment. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who

are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.

b. Screening for ASD may include a review of the individual's overall medical and physical health, hearing, speech, vision, behavioral and developmental status, and screening for ASD with a validated and standardized screening tool.

c. Screening should 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. States are required to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines. EPSDT is made up of the following screening, diagnostic, and treatment services:

    1. Screening Services
    2. Comprehensive health and developmental history
    3. Comprehensive unclothed physical exam
    4. Appropriate immunizations (according to the Advisory Committee on Immunization Practices)
    5. Laboratory tests (including lead toxicity screening)
    6. Health Education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention) https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html

d. Although, best practice indicates a full medical, physical, vision and hearing examination be performed prior to the individual being referred for further autism diagnostic evaluation screening to rule out any physical health conditions, a request for an Autism Diagnostic referral can be requested by parent/guardian and verified by either the individual's Primary Care Physician (PCP) within 6-months of the request for the evaluation. The DWIHN Access Call Center Clinicians will also complete an MCHAT or SCQ at the point of screening to determine if further ADOS-2 diagnostic evaluation is required. Refer to the Eligibility and Screening Policy for additional information.

e. If the screening is positive, either the parent/guardian or PCP can contact DWIHN-Access Call Center directly to schedule a follow-up evaluation.

5. **Referral for Further Evaluation of Autism Spectrum Disorder (MPM 13.2, 18.2)**

    a. There are multiple means for an individual to be referred to the Access Call Center for an ASD screening and comprehensive evaluation, including but not limited to:

        i. Family/self-referral (parent, guardian, other family member)
        ii. Medical providers (PCP, specialists)
        iii. Treatment providers (speech pathologist, occupational therapist, mental health therapist)
        iv. Early-On or education providers

b. DWIHN-Access Call Center verifies eligibility criteria prior to scheduling the diagnostic evaluation:
    i. Active Medicaid insurance assigned to Wayne County
    ii. Residence within Wayne County
    iii. Individual must be under 21 years of age
    iv. Obtain either a positive M-CHAT or SCQ

c. DWIHN-Access Call Center is responsible for contacting, scheduling, and arranging the comprehensive diagnostic evaluation with the appropriate evaluator.

6. **Comprehensive Diagnostic Evaluations (MPM 18.3)**
    a. The comprehensive diagnostic evaluation must be performed before the individual receives the ABA intervention.
    b. DWIHN requires all initial comprehensive diagnostic evaluations to be completed by a provider independent of ABA service delivery to reduce conflict of interest and potential biased during diagnosis.
    c. Clinicians completing evaluations for Michigan Autism Services are required to meet Qualified Licensed Practitioner (QLP) evaluation criteria while demonstrating thorough knowledge of eligibility criteria detailed within the *Medicaid Provider Manual* and *MDHHS Autism Policy,* while ensuring maintenance of appropriate training and credentialing relevant to the provision of services.
    d. The determination of a diagnosis by a qualified licensed practitioner is accomplished by following best practice standards. The differential diagnosis of ASD and related conditions requires multimodal assessment and integration of clinical information. This is a complex assessment procedure in which clinicians must integrate data from caregiver reports, records (e.g., medical, school, other evaluations), collateral reports (e.g., teachers, other treatment providers), data gathered from utilization of standardized psychological tools (e.g., developmental, cognitive, adaptive assessment), and the observational assessment to determine diagnostic and clinical impressions. The utilization of multiple data modes and sources improves the reliability of ASD diagnosis. No one piece of data determines the ASD diagnosis, and evaluators should consider the accuracy of data and confounding factors that may impact data obtained (e.g., parent who seems to be overly negative about the child, child who was intensely shy during observational assessment).
    e. Diagnostic evaluators are responsible for meeting all timeliness deadlines and quality measures.
    f. In cases of transfer between PIHPs or CMHSPs for individuals who were deemed to meet medical necessity criteria for ABA, the initial evaluation from the transferring region should be deemed valid and accepted unless there are clearly extenuating and clinically relevant circumstances (e.g., caregiver or provider recommending/ seeking re-evaluation). DWIHN will accept these evaluations completed outside of DWIHN contracted provider network which meet requirement of MDHHS Autism Policy.

7. **Medical Necessity Criteria & Re-Evaluation (MPM 18.4, 18.8)**
    a. Medical necessity and recommendation for BHT services are determined by a physician or other licensed practitioner working within their scope of practice under state law.
    b. The individual must demonstrate substantial functional impairment in social communication, patterns of behavior, and social interaction as evidenced by meeting criteria A and B in the DSM-V Manual to meet medical necessity for BHT services.
    c. Re-evaluations are required no more than once every three years, unless determined medically necessary to occur more frequently by a physician or other licensed practitioner working within their scope of practice.
        i. If the re-evaluation should occur prior to the standard three years, the clinicians' recommended frequency should be based on the individual's age, developmental level, the presence of comorbid disorders and/or complex medical conditions, the severity level of the individual's ASD symptoms, and adaptive behavior deficits through a person-centered, family-driven youth-guided process involving the individual, family, and treating behavioral health care providers.

8. **Determination of Eligibility for BHT (MPM 18.5)**
    a. Eligibility determination and recommendation for BHT must be performed by a qualified licensed practitioner through direct observation utilizing valid evaluation tools.
        i. A well-established DSM-V diagnosis of ASD from a qualified licensed practitioner utilizing valid evaluation tools.
        ii. Eligibility of an individual diagnosed with autism is dependent on the individual's developmental capacity to clinically participate in the available interventions covered by BHT services.
        iii. Individual is medically able to benefit from the BHT treatment.
        iv. The individuals' symptoms must 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.
        v. The treatment outcomes are expected to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual diagnosed with ASD.
        vi. To obtain benefit approval, the individual must meet both eligibility requirements and medical necessity criteria.
        The date of the initial comprehensive diagnostic evaluation marks the approval date for the autism benefit for individuals who meet all requirements of eligibility for BHT services.
        vii. Evaluations resulting in a non-spectrum diagnosis will result in Notice of Benefit Determination issued by DWIHN for benefit denials.
        viii. At any point, the family and/or individual may voluntarily not show to the

evaluation appointment without any adverse consequences to being eligible for the autism benefit.

ix. The diagnostic evaluating provider is responsible for issuing an Adverse, Adequate or Advanced Notice of Benefit Determination for individuals that do not adhere to the providers appointment policy and/or does not show repetitively for a comprehensive diagnostic evaluation.

x. Approval for the Autism Benefit remains in place up to the member's re-evaluation date.

9. **Authorization of Treatment (MPM 18.6)**

   a. 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. These Standards are outlined in the UM Provider Procedure for Prior Authorized Behavioral Health Services.

   b. Authorization of services cannot exceed IPOS dates, age-out date, or Autism Benefit approval date, whichever comes first.

   c. DWIHN will provide authorization review for all Autism Benefit services. Autism Benefit services are required to be pre-authorized within the Service Utilization Guidelines for ABA services. The assigned ABA Provider to the member is expected to deal promptly with DWIHN for pre-authorizations for services recommended, on behalf of the pursuant to the member's Person-Centered Plan (IPOS). Service provider is expected to work promptly with the Care Manager/Support Coordinator for Person-Centered Planning processes and ensure that all ASD Benefit requirements are completed within required timeliness service under state law.

   d. Authorization requests will be uploaded into MHWIN by the assigned ABA Provider. Refer to ASD Benefit Request Form.
   The assigned ABA provider will notify the assigned Supports Coordinator of the authorization request.

   e. The Support Coordinator will communicate with the ABA provider with information regarding anticipated date that the authorization will be submitted or anticipated date for a meeting with the family to update the IPOS.

   f. The Supports Coordinator will submit the authorization for review.

   g. The Utilization Management team will review and process all authorizations within 14 business days from date of submission.

10. **Suspension, Reduction, Transfer, Re-Engagement, Transition, Discharge and Case Closure Criteria (MPM 18.8)**

   a. Person Centered Plan (PCP)

      1. The Clinically Responsible Service Provider (CRSP), chosen by the member, will be responsible for facilitating the PCP Process and developing, implementing and coordinating the services identified in the IPOS. Refer to the IPOS Individual Plan of Service/Person Centered Plan

for more information.

2. The CRSP and ABA service provider are required on an ongoing basis to monitor their members' activity within their own Electronic Medical Record (EMR) or member's chart as well as within DWIHN's Electronic Medical Record (EMR) known as MH-WIN. Coordination of care should occur no less than once a month between providers.The coordination of care is a critical component to providing whole person-centered care with shared decision-making.
3. Both the assigned Care Manager/Support Coordinator and the ABA service provider is expected to work promptly with the for Person-Centered Planning processes to either suspend, reduce, transfer, re-engage, discharge or close members' case. Refer to the Customer Service Enrollee/Member Appeals Policy for additional policy information.

11. **Behavioral Health Treatment (MPM 18.9)**
    a. Behavioral Assessment (18.9.A.)
        i. A developmentally appropriate applied behavior analysis (ABA) assessment process must identify strengths and weaknesses across domains and potential barriers to progress.
        ii. Behavioral assessments can include direct observational assessment, record review, rating scales, data collection, functional or adaptive assessments, structured interviews, and analysis by a qualified behavioral health professional (QBHP).
        iii. Behavioral assessment tools must describe specific levels of behavior at baseline to inform the individual's response to treatment through ongoing collection, quantification, and analysis of the individual's data on all goals as monitored by a QBHP.
        iv.
    b. Behavioral Intervention (18.9.B.)
        i. DWIHN requires all contracted Clinically Responsible Service Providers (CRSP) to have Behavior Treatment Plan Review Committee (BTPRC). The person-centered planning process is used in the development of an individualized written plan of service (IPOS) will be utilized to identify when a BTP will need to be developed. Members recommended for ABA services with 2:1 staffing ratio must follow the procedural steps necessary to present the members' case at BTPRC. Refer to Procedures for Behavior Treatment Plans in Community Mental Health Settings for additional information.
        ii. 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.
        iii. 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:

1. Shaping, demand fading, task analysis
2. Naturalistic intervention, antecedent based intervention, visual supports, stimulus fading
3. Reinforcement, differential reinforcement of alternative behaviors, extinction
4. Discrete trial teaching, modeling, social skills instruction, picture exchange communication systems, pivotal response training, social narratives, self-management, prompting, chaining, imitation
5. Parent/guardian implemented/mediated intervention
6. Peer mediated instruction, structured play groups, peer social interaction training
7. Video modeling, tablet-based learning software

iv. 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.

v. 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 (18.9.C.)

i. 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.

ii. 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.

12. **BHT Service Level of Care (18.10)**

a. BHT services are available for Medicaid beneficiaries diagnosed with ASD and are provided for all levels of severity of ASD.

b. The behavioral intervention should be provided at an appropriate level of intensity in an appropriate setting(s) within the individual's community for an appropriate period of time, depending on the needs of the individual and their family or authorized representative(s).

c. Clinical determinations of service intensity, setting(s), and duration are designed to facilitate the individual'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 responsibilities of educational or other authorities. Each individual's IPOS must specify how identified supports and services will be provided as part of an overall, comprehensive set of supports and services that does not duplicate services that are the responsibility of another entity, such as a private insurance or other funding authority, and do not include special education and related services defined in the Individuals with Disabilities Education Act (IDEA) that are available to the individual through a local education agency.

d. The recommended service level, setting(s), and duration will be included in the individual's IPOS, with the planning team and the family or authorized representative(s) reviewing the IPOS no less than annually and, if indicated, adjusting the service level and setting(s) to meet the individual's changing needs.

e. The service level includes the number of hours of intervention provided to the individual.

f. The service level determination will be based on research-based interventions integrated into the behavioral plan of care with input from the planning team.

g. Service intensity will vary with each individual and should reflect the goals of treatment, specific needs of the individual, and response to treatment.

h. The PIHP's Utilization Management will authorize the level of services prior to the delivery of services (ABA Service Utilization Guidelines).

13. **BHT Service Evaluation (MPM 18.11)**

    a. 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.

    b. 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.

    c. 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 and other appropriate documentation of analysis (i.e., graphs, assessment reports, records of service, progress reports, etc.).

14. **BHT Service Provider Qualifications (MPM 18.12)**

    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.

    b. The contracted providers will maintain their credentialing and re-credentialing processes and be "audit ready" at all times. These standards are outlined in the Provider Credentialing Monitoring and Auditing policy.

    c. BHT services must be provided under the direction of a BCBA, another appropriately qualified LP or LLP, or a Master's prepared QBHP.

    d. 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.

e. The BCBA and other qualified providers are also responsible for communicating progress on goals to parents/guardians minimally every three to six months; clinical skill development and supervision of 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.

f. The use of medications for the treatment of behavioral health disorders, or psychopharmacology, can be a valuable component in the treatment plan for children and adolescents. However, there are fewer evidence-based studies on their use in children compared to adults; and the pharmacokinetics in children and adolescents is different from adults, and often changes with a child's development. Therefore, BHT service providers should assist the prescribing physician by closely monitor for efficacy and tolerability based on providers direction. These standards are outlined in Psychopharmacology in Children and Adolescents.

    1. BHT service providers should make efforts to coordinate care and exchange information with any treating clinicians for the health and safety of the consumer.
    2. The prescriber is advised to communicate with other professionals involved with the child to obtain collateral history and set the stage for monitoring outcome and side effects during the medication trial.
    3. Each provider organization should have policies and procedures in place to manage medication errors; safe handling and medication control; and credentialing and monitoring/supervision of medical staff to ensure pharmacotherapy-related practices are up to date, safe, and effective.

15. **Description of Services (MPM 18.12.A.)**

    a. ABA therapy is an empirically-based treatment that promotes learning, skill development and behavior change in individuals diagnosed with ASD.

    b. This therapy requires a BHT Supervisor of either a Board Certified Behavior Analyst Doctoral (BCBA-D), Board Certified Behavior Analyst (BCBA), Licensed Psychologist (LP - must be certified as a BCBA by 09/30/25), Limited License Psychologist (LLP-must be certified as a BCBA by 09/30/25), Board Certified Assistant Behavior Analyst (BCaBA) or Qualified Behavioral Health Professional (QBHP-must be certified as a BCBA by 09/30/25) to provide ABA therapy services.

    c. Services provided by a BHT Supervisor include behavioral assessment, behavioral intervention and behavioral observation and direction.

    d. BHT supervisors oversee Behavior Technicians (BT) trained in implementing the behavior plan of care. BT's are supervised at a minimum of one hour of clinical observation and direction for every 10 hours of direct treatment.

    e. BTs 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.

16. **Nondiscrimination of Delivery of Service (MPM 8.4)**
    a. Providers must render covered services to a beneficiary in the same scope, quality, and manner as provided to the general public. Within the limits of Medicaid, providers must take the necessary steps to ensure compliance with all relevant nondiscrimination provisions. Failure to comply may result in the provider's dis-enrollment from the program. Refer to the Compliance Plan policy for additional information.

QUALITY ASSURANCE/IMPROVEMENT

DWIHN shall review and monitor contractor adherence to this policy as one element in its network management program, risk management program, and Quality Assessment/Performance Improvement Program (QAPIP) Work-plan.

The quality improvement programs of Network Providers must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy.

DWIHN shall review and monitor contractor adherence to this policy as one element in its Network Management Program, and as one element of the QAPIP Goals and Objectives.

The Quality Improvement Programs of the direct contractors and their subcontractors, and must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy. DWIHN assesses the demographic characteristics and health risks of its covered population and the data collected and chooses relevant clinical issues that reflect the health needs of significant groups within the population (NCQA QI 10)

COMPLIANCE WITH ALL APPLICABLE LAWS

DWIHN staff, Contracted Network Providers, and their subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

LEGAL AUTHORITY

1. Michigan Department of Health and Human Services Medicaid Provider Manual (in effect, and as amended)
2. Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program (PIHP/CMHSP contracts in effect, and as amended)

RELATED POLICIES AND PROCEDURES

(**Instructions:** Below create a numbered list of policies by name that may be impacted by the development of or changes to this policy so that they may be reviewed when updates are made. Create a

hyper-link to the policy or procedure. Delete this instructions paragraph and text in these parentheses before moving to the next section.)

CLINICAL POLICY

(**Instructions:** The information below is not to be retyped. Does this policy apply to clinical activities? YES or NO? Remove the response that does not apply to this policy. Delete this instructions paragraph and text in these parentheses before moving to the next section.)

YES, NO

INTERNAL/EXTERNAL POLICY

(**Instructions:** The information below is not to be retyped. Does this policy apply only to internal DWMHA operations, or does it apply to external operations as well? Remove INTERNAL or EXTERNAL, as applicable. Delete this instructions paragraph and text in these parentheses before moving to the next section.)

INTERNAL, EXTERNAL

Attachments

ABA_Coding_Coalition_Model-Coverage-Policy_Sept2020_copy.pdf

ABA-ASD-Practice-Guidelines.2014.2nd.pdf

APBA_Guidelines_-_Practicing_During_COVID-19_Pandemic_040920.pdf

ASD Guidelines Revisions 2022 (2).pdf

Clarifications.ASDPracticeGuidelines (1).pdf

Ethics-Code-for-Behavior-Analysts-220316-2 (1).pdf

PIHP-MHSP_Provider_Qualifications_6.23.21.pdf

Approval Signatures

Step Description	Approver	Date
Stakeholder Feedback	Allison Smith: Project Manager	Pending
Compliance/Administrative Review	Yolanda Turner: VP of Legal Affairs	02/2024

Compliance/Administrative Review	Tiffany Devon: Director of Communications	02/2024
Compliance/Administrative Review	Sheree Jackson: Vice President of Compliance	02/2024
Compliance/Administrative Review	Stacie Durant: VP of Finance	02/2024
Compliance/Administrative Review	Manny Singla: Executive VP of Operations	01/2024
Clinical Review Committee	Leigh Wayna: Director of Utilization Management	01/2024
Clinical Review Committee	Jacquelyn Davis: Clinical Officer	01/2024
Clinical Review Committee	Shama Faheem: Chief Medical Officer	01/2024
Clinical Review Committee	Judy Davis: Director of Substance Abuse Disorders	01/2024
Clinical Review Committee	Melissa Moody: VP of Clinical Operations	01/2024
Clinical Review Committee	Ebony Reynolds: Clinical Officer	01/2024
Clinical Review Committee	Kathryn Mancani: Interim Director of Residential Assessments	01/2024
Clinical Review Committee	Vicky Politowski: Director of Integrated Care	01/2024
Clinical Review Committee	Daniel West: Director of Crisis Services	01/2024
Clinical Review Committee	April Siebert: Director of Quality Improvement	01/2024
Clinical Review Committee	Polly McCalister: Director of Recipient Rights	01/2024
NCQA Committee	Shana Norfolk: Strategic Planning Administrator	01/2024
NCQA Committee	Tania Greason: Quality Administrator	01/2024
NCQA Committee	Allison Smith: Project Manager	12/2023
NCQA Committee	Maria Stanfield: Director of Strategic Operations	12/2023
Unit Review and Approval	Cassandra Phipps: Director of Children's Initiatives	12/2023

Unit Review and Approval	Rachel Barnhart: ASD BenefitProgram Administrator	12/2023