Policy:

Palmer's Home Care works to provide the highest quality of Applied Behavioral Analysis (ABA) and Behavior Therapy services for individuals with intellectual/developmental disabilities while adhering to the Department of Mental Health rules and regulations.

Comment:

Palmer's Home Care will provide individualized Applied Behavioral Analysis (ABA) and Behavior Therapy to individuals who meet the Department of Mental Health guidelines for Developmental Disabilities in our service with our Behavioral Therapy.

Procedure:

Palmer's Home Care ABA therapists will meet with individuals for intake assessments. If Palmer's is able to assist in behavioral services, then a funding request will be made through the service coordinator. The assessment will assist in determining what supports will be needed and requested from the Medicaid Waiver.

Once the funding has been approved through the Medicaid Waiver, the ABA services will begin according the need of the individual and the availability of Palmer's Behavioral Services staff. Documentation and case notes will be kept for each service billed within Department of Mental Health standards.

Service Description: Applied Behavioral Analysis (ABA) **from DD Waiver Manual 9/1/23**

ABA services are intended to help individuals who have challenges in the areas of behavior, social and communication skills in acquiring functional skills in their homes and communities and/or preventing hospitalizations or out-of-home placements. ABA services may assist individuals in learning new or functionally equivalent replacement behaviors that are directly related to existing challenging behaviors or functionally equivalent replacement behaviors for identified challenging behaviors. Services may also be provided to increase existing behavior, reduce existing behavior and emit behavior under precise environmental conditions. ABA services include the design, implementation and evaluation of systematic environmental modifications for the purposes of producing socially significant improvements in and understanding of human behavior based on the behavioral principles identified through experimental analysis.

Central to the implementation of appropriate ABA services is the Behavior Support Plan (BSP), which is a treatment plan that involves the following elements:

• Strategies and procedures described to generalize and maintain the effects of the BSP, as well as data collection to assess the plan's effectiveness and fidelity of implementation

• Specific skills and behaviors targeted for each individual should be clearly defined in observable terms and measured carefully by direct observation each session

• Data collection by the staff, family and/or caregivers who are the primary implementers of the plan; data monitoring from continuous assessment of the individual's skills in learning, communication and social competence; and a self-care guide to the scope of the Individual Support Plan (ISP), which must include separate, measurable goals and objectives with clear definitions of what constitutes mastery

• Reports regarding the service must include data displayed in graphic format with relevant environmental variables that may affect the target behaviors indicated on the graph. The graph should provide an indication of the analysis via inclusion of environmental variables including medications and changes in medications, baseline or pre-intervention levels of behavior and strategy changes.

• Performance-based training for parents, caregivers and significant others in the person's life if these individuals are integral to the implementation or monitoring of the plan.

Types of Applied Behavior Analysis Services

There are two primary types of ABA services; Assessment Services and Adaptive Behavior Treatment services. Each of these services are described in detail below.

Assessment Services

Assessment Services analyze the situation and lead to recommendations (described in the BSP) for how to address the issues. A descriptive assessment (called Functional Behavior Assessment (FBA)) is comprised of a Behavior Identification Assessment and a Behavior Identification Assessment - Observational, and possibly a Behavior Identification Supporting Assessment-Exposure.

ABA services are based on an assessment that identifies functional relationships between behavior and the environment, such as contextual factors, establishing operations, antecedent stimuli, contributing and controlling consequences, and possible physiological or medical variables associated with challenging behaviors or situations. The assessment also includes the following components:

• A Behavior Identification Assessment is completed by the physician or other Qualified Health Care Professional (QHCP), face-to-face with the patient and the caregiver(s). It includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s) and preparation of the report.

• A Behavior Identification Supporting Assessment-Observational is the observational assessment may be required to finalize or fine-tune the baseline results and plan of care initiated during the identification assessment. This service is performed by a Registered Behavior Technician (RBT) under the direction of a QHCP or Licensed Assistant Behavior Analyst (LaBA). During the face-to-face assessment process, the QHCP or LaBA may or may not be present. Individuals who present with specific destructive behaviors (e.g., self-injurious behavior, aggression, property destruction) or behaviors or deficits in communication or social relatedness are given this assessment. Observational follow-up includes structured observation and/or standardized and non-standardized tests to determine levels of adaptive behavior. Areas assessed

may include cooperation, motivation, visual understanding, receptive and expressive language, imitation, requests, labeling, play and leisure and social interactions. Specific destructive behavior(s) assessments include structured observational testing to examine events, cues, responses and consequences associated with the behavior(s).

• A Behavior Identification Supporting Assessment-Exposure is administered by the QHCP with the assistance of one or more RBTs. This assessment includes the QHCP's interpretation of results, discussion of findings and recommendations with primary caregiver(s) and preparation of report. Typical individuals for these services include those with more specific severe destructive behavior(s) (e.g., self-injurious behavior, aggression, property destruction). Structured testing is used to examine events, cues, responses and consequences associated with severe destructive behavior(s). This assessment includes exposing the individual to a series of social and environmental conditions associated with the destructive behavior(s). Assessment methods include using testing methods designed to examine triggers, events, cues, responses and consequences associated with the previously mentioned maladaptive behavior(s). To ensure safety, this assessment must be completed in a structured environment.

Adaptive Behavior Treatment

Adaptive Behavior Treatment services are made up of several different methods of treatment, most of which could be used alone, but far more frequently are used in various combinations. Adaptive Behavior Treatment with Protocol Modification, which could be a stand-alone service if that was the recommendation of the assessment, is likely used in combination with Adaptive Behavior Treatment by Protocol by Technician or Exposure Adaptive Behavior Treatment with Protocol Modification.

Family Adaptive Behavior Treatment Guidance and Adaptive Behavior Treatment Social Skills Group are not stand-alone services, but might be used in conjunction with the services above.

Adaptive Behavior Treatment addresses the individual's specific target problems and treatment goals as defined in previous assessments. Adaptive behavior treatment is based on principles including: analysis and alteration of contextual events and motivating factors, stimulus-consequence strategies, replacement behavior and monitoring of outcomes. Goals of adaptive behavior treatment may include reduction of repetitive and aberrant behavior, improved communication and social functioning. Adaptive behavior skill tasks are often broken down into small, measurable units, and each skill is practiced repeatedly until mastered. Adaptive Behavior Treatment may occur in multiple sites and social settings (e.g., controlled treatment programs with individual alone or in a group setting, home or other natural environment). All ABA services are considered short-term services, with the goal of providing changes in patterns of interactions, daily activities and lifestyle including provider family/staff/caregivers skills to teach the individuals adaptive skills and skills that address problem behaviors. Individual and family/staff/caregivers skill development is a key component of these services. In addition, it is essential that the developed strategies be adapted to more common types of support strategies so that the BSP is replaced with these more common strategies as the service is successful.

• Adaptive behavior treatment is further composed of the following elements: The Adaptive Behavior Treatment by Protocol by Technician (on-site or off-site) is administered by a single RBT or LaBA under

the direction of the QHCP while adhering to the QHCP's protocols. This service is delivered to the individual either alone or as part of a group session. This includes skill training delivered to an individual who, for example, has poor emotional responses (e.g., rage with foul language and screaming) to deviations from rigid routines. The RBT introduces small, incremental changes to the individual's expectedroutine along one (1) or more stimulus dimension(s), and a reinforcer is delivered each time the individual appropriately tolerates a given stimulus change until the individual tolerates typical variations in daily activities.

The QHCP directs the treatment by designing the overall sequence of stimulus and response fading procedures, analyzing the RBT-recorded progress data to assist the RBT in adhering to the protocol and judging whether the use of the protocol is producing adequate progress.

• The Adaptive Behavior Treatment with Protocol Modification is administered face- to-face by a QHCP or LaBA. The service may include a demonstration of the new or modified protocol to a RBT, guardian(s), and/or caregiver. For instance, Adaptive Behavior Treatment with Protocol Modification will include treatment services provided to a teenager who has been placed with a foster family for the first time and is experiencing a regression of the behavioral targets that were successfully met in the group-home setting due to the individual's atypical sleeping patterns. The clinical social worker modifies the previous protocol targeted for desired results to incorporate changes in the context and environment. The QHCP demonstrates a modified treatment protocol to show the new caregiver how to apply the protocol(s) to facilitate the desired sleeping patterns to prevent sleep deprivation.

• Exposure Adaptive Behavior Treatment with Protocol Modification: This treatment is provided to individuals with one or more specific severe destructive behaviors (e.g., self-injurious behavior, aggression, property destruction), with direct supervision by a QHCP and requires two (2) or more RBTs face-to-face with the individual for safe treatment. RBTs elicit behavioral effects of exposing the individual to specific environmental conditions and treatments. RBTs document all occurrences of targeted behaviors. The QHCP reviews and analyzes data and refines therapy using single-case designs; ineffective components are modified or replaced until discharge goals are met (e.g., reducing destructive behaviors by at least 90%, generalizing treatment effects across caregivers and settings or maintaining treatment effects over time). The treatment is conducted in a structured, safe environment. Precautions may include environmental modifications and/or protective equipment for the safety of the individual and RBTs. Depending on the severity of the behavior these services are provided in intensive outpatient, day treatment or inpatient facilities.

• The Family Adaptive Behavior Treatment Guidance is provided face-to-face by a QHCP or LaBA to family/guardian(s)/caregiver(s) and involves teaching family/guardian(s)/caregiver(s) to use treatment protocols designed to reduce maladaptive behaviors and/or skill deficits.

• The Adaptive Behavior Treatment Social Skills Group is administered by a QHCP or LaBA face-to-face with multiple individuals, focusing on social skills training and identifying and targeting individual patient social deficits and problem behaviors. The QHCP or LaBA monitors the needs of individuals and adjusts the therapeutic techniques used during the group, as needed. Services to increase target social skills may include modeling, rehearsing, corrective feedback and homework assignments. In contrast to adaptive

behavior treatment by protocol techniques, adjustments are made in real time rather than for subsequent services.

When providing ABA services via telehealth, please refer to Section 7 in this manual for additional requirements.

For individuals who are hospitalized, ABA services may be provided to assist with supports, supervision, communication and any other supports that the hospital is unable to provide. The service must be identified in an individual's person-centered service plan and provided to meet needs that hospital services do not meet. Services cannot be substituted for those that the hospital is required to provide under its conditions of participation, federal or state law or under another applicable requirement. Services must be designed to ensure smooth transitions between acute care settings and Home and Community Based (HCB) settings, while also preserving the individual's functional abilities.

Service Limitations: Applied Behavioral Analysis (ABA) **from DD Waiver Manual 9/1/23**

ABA services are limited to additional services not otherwise covered under the Medicaid state plan, including Healthy Children and Youth (HCY), MO's Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, but consistent with waiver objectives of avoiding institutionalization. See the Billing Information: Applied Behavior Analysis section for maximum units of service regarding ABA.

Provider Requirements: Applied Behavioral Analysis (ABA) **from DD Waiver Manual 9/1/23**

Services may be provided by a QHCP, a LaBA under the supervision of a QHCP who is an LBA, or an RBT under the supervision of a QHCP who is an LBA.

An individual or an agency must have a contract with DMH.

A QHCP must have a graduate degree and MO State license as a Behavior Analyst or a licensed professional in psychology, social work or professional counseling with training specific to behavior analysis (RSMo Chapter 337 and 376 specifically 337.300; 337.305; 337.310; 337.315; 337.320; 337.325; 337.330; 337.335; 337.340; 337.345; 376.1224).

A LaBA must have a MO State license as an assistant Behavior Analyst (RSMo Chapter 337 and 376 specifically 337.300; 337.305; 337.310; 337.315; 337.320; 337.325; 337.330;

337.335; 337.340; 337.345; 376.1224).

The RBT must be registered with the Behavior Analyst Certification Board.

ABA services can be provided by a person enrolled in a graduate program for ABA and completing the experience requirements with ongoing supervision by a LBA in the state of MO who is a contracted provider for the MO HealthNet Division (MHD). These services provided by a person as part of the

experience requirement and under the supervision of the LBA will be considered as the equivalent of LaBA services for purposes of billing and eligibility to provide particular ABA services.

Palmer's Home Care Staff Requirements

All direct-care staff must be 18 years of age and have a HS diploma or its equivalent.

Exemptions to HS diploma/GED requirement:

- Staff without diplomas or GEDs employed by the same provider prior to July 1, 1996 will be "grandfathered"
- Staff without diplomas or GEDs may be employed for up to one (1) year while working toward the requirement. The provider must document the staff's enrollment in school or GED courses.
- After July 1, 1996, staff without diplomas or GEDs who already have five (5) or more years of direct working experience may be employed with the approval of the Division of DD regional office. The provider is responsible for maintaining documentation of the five (5) years of experience and of regional office agreement in the employee's file.

All direct-care staff shall have training that covers at a minimum:

- Training, procedures and expectations related to this service in regards to following and implementing the ISP
- Training in implementation of each individual's current support plan/addendums shall be completed within one (1) month of the implementation date of the current plan, or within one (1) month of employment for new staff
- Training in preventing, detecting and reporting of abuse/neglect prior to providing direct support
- Current certification in competency-based CPR and First Aid courses
- Staff administering medication and/or supervising self-administration of meds must have successfully met the requirements of 9 CSR 45-3.070
- Training in positive behavior support curriculum approved by the Division of DD within three (3) months of employment

Billing Information: **Applied Behavioral Analysis (ABA)** **from DD Waiver Manual 9/1/23**

Waiver Service	MHD Procedure Code	MHD Modifier 1	
Assessment			
Behavior Identification Assessment Q	97151	HO	32 units per year
Observational Behavioral Follow-Up Assessment Q	97152	HO	16 units per day,50 units per week, 50 units per year

Observational Behavioral Follow-Up Assessment L	97152	HN	16 units per day,50 units per week, 50 units per year
Observational Behavioral Follow-Up Assessment R	97152	HM	16 units per day,50 units per week, 50 units per year
Exposure Behavioral Follow-Up Assessment Q	0362T	HO	32 units per day, 100 units per year
Treatment			
Adaptive Behavior Treatment with Protocol Mod. Q	97155	HO	32 units per day, 120 units per week, 270 units per month
Adaptive Behavior Treatment with Protocol Mod. L	97155	HN	32 units per day, 120 units per week, 270 units per month
Exposure Adaptive Beh. Treatment w/Protocol Mod. Q	0373T	HO	34 units per day, 130 per week, 320 units per month
Adaptive Beh. Treatment by Protocol by Technician Q	97153	HO	32 units per day, 160 units per week, 600 units per month
Adaptive Beh. Treatment by Protocol by Technician L	97153	HN	32 units per day, 160 units per week, 600 units per month
Adaptive Beh. Treatment by Protocol by Technician R	97153	HM	
Family Behavior Treatment Guidance Q	97156	HO	40 units per month
Family Behavior Treatment Guidance L	97156	HN	40 units per month
Behavior Treatment Social Skills Group Q	97158	HO	6 units per day, 30 units per week, 60 units per month
Behavior Treatment Social Skills Group L	97158	HN	6 units per day, 30 units per week, 60 units per month

Service Documentation: Out of Home Respite

The provider must maintain service documentation as per the requirements set forth in Section 3 of this manual, including detailed progress notes per date of service and monthly progress notes associated with objectives listed in the ISP and the individual BSP. Progress notes should be written at least monthly and include data regarding program fidelity, any concerns from QHCP or other members of the planning team, and data with respect to implementation effects. The progress notes should also include a summary of contacts made by family, caregivers, etc., and any actions taken and modifications made to the BSP. Graphic presentation of data and interpretation of the data shall be included in the progress

notes submitted to the planning team and support coordinator. The FBA must not be billed until the assessment is complete and the FBA report has been finalized and received by the support team.

A copy of the written individual BSP, graphic data and progress notes from the period the service is provided must be included with the written individual plan of care upon termination of services. This information will be filed in the individual's chart, located in the Division of DD regional office or with the TCM entity with whom the individual is enrolled.