CMHCM Autism Provider Meeting

August 30, 2023

Autism Supervisor: Mary Schrier, MA LBA BCBA CMHP

Referral Process

Referral Form

* Referral form is emailed to provider and includes:
  * Family contact info
  * Case holder name
  * Requested date for start of initial authorizations (verify auths are in before providing services)
  * Start Date Deadline (expected to start with tech and/or family training within 90 days of referral)

ABA Services authorized for: Consumer Name   **Date of Authorizations:** Click here to enter a date.
Before providing services please confirm auths are in CIGMMO and IPOS training has been completed.

Service with Description	Code	Unit of Service	Authorized
ABA Assessment & Treatment Plan Behavior identification assessment (eg VB-MAPP, AFLS, etc) Includes: review of documents, interview with parents, consumer observation, and discussion of results with parents/consumer. *Report face-to-face contact in progress note.*	97151	15 min	32
Family Behavior Guidance: Individual family training on plan & ABA techniques. *Can overlap other face-to-face services with consumer.*	97156	15 min	12 per month
Multiple Family Behavior Guidance Group family training. Maximum of 8 families. *Can overlap other face-to-face services with consumer.*	97157	15 min	If requested
Functional Behavior Assessment Observation, direct testing to determine function of behavior.	0362T	15 min	12
Adaptive Behavior Treatment: 1:1 tech to consumer 1:1 implementation of ABA treatment plan as developed by BCBA or other qualified professional in consultation with family.	97153	15 min	Based on plan
Exposure Adaptive Behavior Treatment: 2:1 techs to consumer Two techs implement treatment plan with protocol modification for severe maladaptive behaviors. *Only one encounter reported for time for both techs.* Must be pre-approved by the Behavior Treatment Committee.	0373T	15 min	If requested
Group Adaptive Behavior Treatment: 1:2 techs to consumers One tech implements treatment plans simultaneously with 2 consumers.	97154	15 min	If requested
Social Skills Group: Maximum 8 consumers Implementation, by a Behavior Analyst, of adaptive behavior treatment social skills in a group setting.	97158	15 min	If requested
Clinical Observation & Direction Observation of technician implementing behavior treatment plan with fidelity; Direction may include protocol demonstration to technician.	97155	15 min	15-20% of intervention hours

Deadline for services to begin: Click here to enter a date.

Referral Notes

* If you can't accept a referral please reply to the email within 1 week so the consumer can be re-assigned.

* If you can't reach the family within 2 weeks please follow up with case holder for assistance.

* If the consumer is transferred from another provider please review the most recent ABA plan for a smooth, consistent transition.

Chart Access

* Karen Chapin assigns provider in CIGMMO
  * Once clinician is assigned provider notifies Karen so she can give access to the case.
  * Provider checks for auths
  * Autism evaluation can be reviewed
* Case holder trains provider on PCP/IPOS
  * Provider trains techs on the PCP

Initial Auths

* When a new consumer is referred the case holder is asked to enter the following auths:
    * 97151:   32 Units/auth – (semi-annual ABA assessment)
    * 0362T: 12 Units/auth (FBA assessment, as needed)
    * 97156: 4 Units/month (parent training)

* Please ensure the auths are in place before providing services.

Before Starting

* Staff must be credentialed and trained
  * Trained on IPOS, ABA plan and CIGMMO

Training on IPOS

* Following referral case holder arranges with provider to train someone from agency on the PCP/IPOS.
* Prior to initial assessment provider staff is verbally trained by case holder, who documents training in PCP document.
* Provider trains other ABA staff on the IPOS prior to working with consumer. Training is documented in CIGMMO as PCP attachment.
* Training also occurs with annual PCPs.

IPOS Training Documentation

ELECTRONIC TRAINING RECORD INSTRUCTIONS

* Training is documented as attachment to the PCP.

CIGMMO

* Consumer Charts
  * Consumer Information
  * Person Centered Plans
  * Progress Notes
  * AUTISM section (new)
* Messages
* Authorizations

CMHCM **CIGMMO Access Request**

User name: _____

Provider: _____

Supervisor: _____

Type of access requested - select one:

Billing ☐	**Clinical** ☐
Select this option for billing access. Phone training to be provided by Payables team.	*Select this option if the user is a licensed provider staff who enters documentation for services directly into CIGMMO. Training required and scheduled once credentials verified.*
PCP/Chart View ☐	**Clinical Supervisor** ☐
Select this option if the user views consumer charts, trains on person-centered plans (PCP), and/or uploads documents. No formal training provided or required.	*Select this option if the user is a clinical supervisor of provider staff and will view consumer charts and enter consultation notes in CIGMMO. Training required and scheduled once credentials verified.*
Home Manager ☐	**Direct Care Worker** ☐
Select this option if the user enters and manages Specialized Residential documentation and reports in CIGMMO. No formal training provided or required.	*Select this option if the user will be entering Specialized Residential documentation in CIGMMO. No formal training provided or required.*
ABA Transcription ☐	
Select this option if the user will be data entering autism forms to be signed by an ABA clinician.	

A signed CMHCM Computer Use Agreement MUST accompany <u>all</u> access requests

Please complete the following information for ***<u>Clinical staff</u>*** requesting access:

Start Date: _____

Professional License: _____

Other Credentials (QBHP, CMHP, QMHP, QIDP): _____

NPI: _____

Degree: *(highest achieved – check one)*

Physician Medical ☐	Bachelor's Degree ☐
Doctorate ☐	Associate's Degree ☐
Master's Degree ☐	High School Diploma ☐

Please send completed form and signed CMHCM computer use agreement to:
CMHCM Provider Network Team providernetwork@cmhcm.org

Staff access to CIGMMO

* **Clinical** – is for the clinician (BCBA, BCaBA or QBHP) who provides services
* **Clinical Supervisor** – supervises the clinician, can enter consultation notes, but does not have access to enter progress notes.
* **ABA Transcription** – has access to enter data and upload reports into the Autism Diagnostic Evaluations, Autism Monthly Reports, and Autism Assessments.

CIGMMO Training

* After Amanda receives the required forms she provides link to online CIGMMO training.

* Virtual Q & A session (offered at 9 am on Tuesdays and Thursdays) is scheduled to review training.

* Clinician cannot provide billable services until after completing the training and Q&A.

Progress Notes

* Clinician Progress Notes
  * Enter and sign within 24 hours of service
  * In Discussion include:
    * 97151: All direct and indirect hours on assessment
    * 97155: Name of technician supervised
    * 97156: Caregivers involved in training
  * Attachment of outside progress note is fine as long as clinician signs CIGMMO note.

Progress Notes

* Behavior Tech Progress Notes
  * Not entered in CIGMMO, but can be uploaded to Autism Scanned Documents
  * Include:
    * Consumer name and/or ID
    * Narrative and data on interventions used toward goals in ABA Treatment Plan

Community Mental Health for Central Michigan
Therapeutic Behavioral Service Progress Notes

Consumer Name: _____   **Consumer ID:** _____

Therapeutic Behavioral Service Goal/Objective in PCP:

Check the following goals that were focused on during this session:

[   ] Goal 1- ABCD
[   ] Goal 2- ABCD
[   ] Goal 3- ABCD
[   ] Goal 4- ABCD

Date: _____   **Start Time:** _____   **Stop Time:** _____

Please provide a narrative on what occurred with this consumer (so if an outsider were reading this, they would be able to reconstruct your shift). If additional space is needed, please use the back side of this progress note. If two consumers, complete separate notes for each consumer. If two behavioral technicians, both must sign.

Include narrative on what programs were completed during session, frequency data for any behavioral reduction programs, vocal opportunity frequency data, feeding intake and toileting information. Reinforcers used during session or activities completed.

☐ 1 Behavioral Technician:1 Consumer   ☐ 2 Behavioral Technicians:1 Consumer   ☐ 1 Behavioral Technician:2 Consumers

_____   _____   _____
Staff Printed Name   *Staff Signature/Credentials*   *Date*

_____   _____   _____
Staff Printed Name   *Staff Signature/Credentials*   *Date*

Date: _____   **Start Time:** _____   **Stop Time:** _____

Please provide a narrative on what occurred with this consumer (so if an outsider were reading this, they would be able to reconstruct your shift). If additional space is needed, please use the back side of this progress note. If two consumers, complete separate notes for each consumer. If two behavioral technicians, both must sign.

☐ 1 Behavioral Technician:1 Consumer   ☐ 2 Behavioral Technicians:1 Consumer   ☐ 1 Behavioral Technician:2 Consumers

_____   _____   _____
Staff Printed Name   *Staff Signature/Credentials*   *Date*

New Autism Section

Autism
ABA Consumer Profile
Autism Diagnostic Evaluations
Autism Monthly Reports
Autism Assessments
Autism Scanned/Uploaded Documents

* Autism Diagnostic Evaluations – Includes ADOS report
* Autism Assessments – Semi-annual assessment reports with training documents
* Autism Scanned/Uploaded Documents – Old documents, tech progress notes, and miscellaneous

Autism Assessments

* Upload current ABA assessment into this tab

* Upload documentation of any staff trained on this plan

* Upload extra documents such as school/ABA schedules

Assessment from the past 6 months MUST be uploaded into this section in order to have current ABA authorizations approved.

Autism Assessments

* Evaluation Type:
  * Choose INITIAL if first ever eval
  * Choose SECOND for ALL re-evals by same provider
  * Choose OTHER if First eval by new provider, put that in text box
  * Don't use Third or Fourth
* Date of Evaluation
  * Date completed
  * Progress note should match

1. Autism Assessment: Autism Assessment

Evaluation Type
○ Initial Evaluation ○ Second Evaluation ○ Third Evaluation ○ Fourth Evaluation
○ Other:

Date of Evaluation   **Provider** **lookup**

Use Current Date

Evaluator

Evaluation Instruments

☐ **VB-MAPP** (Verbal Behavioral - Milestone Assessment and Placement Program)

☐ **ABLLS-R** (Assessment of Basic Language and Learning Skills)

☐ **AFLS** (Assessment of Functional Living Skills)

☐ **PEAK** (Promoting the Emergence of Advanced Knowledge) Relational Training System

☐ Other, specify:

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Date of evaluation is used to determine due date of next semi-annual assessment.

Autism Assessments

* Evaluation Instruments:
  * If one of these 4 additional boxes pop up to enter scores.
  * Not required to be one of these instruments.
* Recommended Services – Should be REQUESTED services
  * These should match auths and the actual amount scheduled.
  * For supervision I typically authorize 15% of direct hours, unless up to 20% is requested. More than 20% needs rationale and approval.
* Ancillary Services –
  * This is not used for authorizations, only information purposes.

Evaluation Instruments

☐ **VB-MAPP** (Verbal Behavioral - Milestone Assessment and Placement Program)

☐ **ABLLS-R** (Assessment of Basic Language and Learning Skills)

☐ **AFLS** (Assessment of Functional Living Skills)

☐ **PEAK** (Promoting the Emergence of Advanced Knowledge) Relational Training System

☐ Other, specify:

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Recommended Services

Applied Behavioral Analysis Therapy: [____] hours per week

Supervision: [____] hours per week

Family Training: [____] hours per month

Ancillary Services:

☐ Speech Therapy   ☐ Occupational Therapy   ☐ Physical Therapy

Initial Assessment

* Enter Initial Assessment into Assessment tab and complete a progress note in CIGMMO.
  * Signed progress note, which is required for billing, should include all of the direct and indirect time spent on the assessment, dated when assessment is completed.

Auths for Tech to begin

* Email Authorization Request form, with ABA schedule and requested start date to Mary Schrier and Karen Chapin.
* Form should be emailed 2-3 weeks before start date.
  * *Auths can be requested with a preliminary treatment plan in order to meet time requirements. Notify Mary if any changes are needed to goals or auths after the plan is finalized and signed by parents.*
* Confirm that auths are entered **prior** to tech providing services.

Auth Request Form

CMHCM ABA Authorization Request
Please attach an addendum to the PCP plan of:
Consumer: Enter name   Case #: Enter case number   Date: Click here to enter a date.

Reason for Addendum:
□ *ABA Service Change*   □*New PCP*   □ *Change in ABA Goals/Objectives*
   □   New services
      □   Assessment
      □   Intervention w behavior tech starting
   □   Change in BCBA supervision   Name:_____
   □   Change in service hours per week
      □   Per family request
      □   Other:_____

Are there currently ABA services authorized?   **Yes**   **No**
(Note to caseholder: If yes please early terminate the auths of the corresponding code from below.)

Are any changes needed to the assessment or parent training auths?   **Yes**   **No**
   Please change:
   □ 97151 _____ Units/Year – (autism assessment, required every 6 months)
   □ 0362T _____ Units/Year (FBA assessment, as needed)
   □ 97156 _____ Units/MONTH (parent training)

Please Add the Following Authorizations: Provider: _____
Date: Click or tap to enter a date. The date the tech will begin with consumer or change needs to take place. (It needs to be requested at least 2 weeks prior.)
   □ 97153: _____ Units/Week (Direct ABA therapy, 1:1 consumer to tech) Enter Weekly Hours hours)
   □ 97155: _____ Units/Week (ABA Clinical Observation and Direction of intervention)

ABA Weekly Schedule: ***School Weekly Schedule:**
Mon: _____   Mon:_____
Tues: _____   Tues: _____
Wed: _____   Wed:_____
Thurs: _____   Thurs: _____
Fri: _____   Fri: _____
Sat: _____   *School schedule is required if: over 6 yrs old,
Sat: _____   with more than 16 hours of ABA per week.

Signature: _____   Date submitted: __ Click here to enter a date.

Annotations:

If there are current authorizations that will be changed mark YES.

(If schedule is changing mark YES!)

These are requested with a standard number annually. Unless changes are needed mark NO.

This should be the date the TECH begins working with consumer. Must include start date! Even if it is tentative.

If school age schedule must be completed, even if student is homeschooled or participating in virtual school.

Requesting Direct Authorizations

* Request auths 2-3 weeks prior to start date
  * Before tech begins
  * When schedule and/or staff change
* Use Auth Request Form, including ABA schedule and start date
* Units of 97153 requested need to match ABA schedule
* If 2:1 staffing is requested it must be approved by the Behavior Treatment Committee before the auths are added.
* Auths will only be approved if a current assessment is in the chart.

Authorizations

* Services **cannot begin** until authorizations are in place.
* Providers are responsible to ensure authorizations are correct in CIGMMO prior to starting services.
* If auths are not in place contact the Autism Supervisor and case holder prior to providing service.

Reminder we cannot backdate auths!

Check for Authorizations

Direct Therapy auths

Authorized Service Description		Units Authorized	Units Claimed to Date	Units Paid to Date	Units Available
97153	ABA Adaptive behavior treatment by protocol, administered by technician	40 Per Week Total:2086	630	630	1456
				12/14/21-12/13/22	
97155	ABA Clinical Observation and Direction of Adaptive Behavior Treatment	6 Per Week Total:313	69	69	244
				12/14/21-12/13/22	

- Units authorized of 97153 should be 4 times the number of hours of direct ABA per week
- Make sure number of units and "per week" are correct
- Check the start and end dates

Training Techs on Plan

* Train techs on new treatment plan prior to its implementation.

* New techs must be trained prior to working with the consumer.

* Upload training documents and attach to Autism Assessment.

  * Attachment Type is Training Record.

  * Date is Date of Training.

  * In Notes include name of tech "trained on ABA Plan."

STEP 2 – Attachment Information

To identify the file that you are uploading, please complete the following information.

Attachment Type

* Select an attachment type ▾

| * Select an attachment type |
| Consumer Signatures |
| Supporting Documentation |
| Training Record |
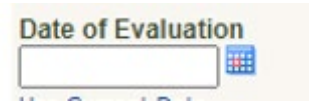
Attachment Date

Use Current Date

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Semi-Annual Assessments

* Semi-annual assessments must be completed within every 6 months.

* The due date is six months from the date of the most recent assessment based on the date entered.

* If goals, objectives or auths are needed outside of the annual PCP directly email the case holder, Mary Schrier, and Karen Chapin, attaching the Addendum Authorization Request Form.

Monthly Reports

Monthly Reports

Agency:		Month/Year:		Completed by:							
Initial Information				**Units Utilized**			**Dates re: current treatment plan**				
Consumer	Initial ABA Assessment	ABA Start date	Name of BCBA, BCaBA, QBHP	Direct ABA provided (97153)	Total Supervision provided (97155)	Parent Training provided (97156)	Date of most recent assessment	Date of parent review	Implementation Date of new plan	Date tech trained	Expiration date of current auths

* Monthly updates of utilization should be completed in the Excel Spreadsheet and emailed to Karen Chapin, kchapin@cmhcm.org, by the end of each month.

Initial Information

* Consumer name
* Initial ABA Assessment
* ABA Start Date (do not start until auths are in)
* Name of supervising BCBA, BCaBA or QBHP

Units Utilized

Should be updated monthly

* Authorized hours of direct service must be within 25% of hours provided for the month.

* Supervision must be provided at least 10% of the direct hours provided in a month.

* Parent training is expected monthly.

Dates

Should be updated with new plans and auths

* Date of most recent assessment

* Date reviewed plan with parent

* Date new plan is Implemented (Should be the effective date on Training Record)

* Date tech was trained on plan (documentation should be attached to Autism Assessment tab)

* Expiration date of current auths

Other Reminders

Functional Behavior Assessments

* Auths are always available for a clinician to begin a FBA as needed, without waiting for approval.

* If severe problem behaviors are occurring, such as aggression to self or others, property destruction, or elopement, an FBA should take place and a Safety/Crisis plan should be developed with the family.

* Upload FBA into the Autism tab in CIGMMO, and choose "Send Copy To" for Mary Schrier to review and email an alert to review.

* ALL Restrictive or Intrusive intervention requires prior approval from the Behavior Treatment Committee.

* Complete the Safety/Crisis template in CIGMMO.

BTC Requests

* MDHHS requires the Behavior Treatment Committee "to review (at least quarterly) and approve or disapprove of any plans that propose to use restrictive or intrusive interventions."

* Requesting the use of 2:1 staffing requires prior approval by the BTC and quarterly reviews.

BTC Review Request

* To request a review by the BTC work with the Autism Supervisor and the case holder to complete the form and compile necessary documents.

* The more details regarding about what has been attempted, how and why the proposed intervention should work, and a fading plan the better the chance of approval.

* Members of the BTC team are willing to meet with providers to discuss what is needed and what can or can't be approved.

Documents needed for BTC

1. Results of assessments performed to rule out relevant physical, medical and environmental causes of the challenging behavior.

2. A functional behavioral assessment.

3. Results of inquiries about any medical, psychological or other factors that might put the individual subjected to intrusive or restrictive techniques at high risk of death, injury or trauma.

4. Evidence of the kinds of positive behavioral supports or interventions, including their amount, scope and duration that have been used to ameliorate the behavior and have proved to be unsuccessful.

5. Evidence of continued efforts to find other options.

6. Peer reviewed literature or practice guidelines that support the proposed restrictive or intrusive intervention.

7. References to the literature should be included on new procedures, and where the intervention has limited or no support in the literature, why the plan is the best option available. Citing of common procedures that are well researched and utilized within most behavior treatment plans is not required.

8. The plan for monitoring and staff training to assure consistent implementation and documentation of the intervention(s).

Parent Training

* Auths for Parent Training (97156) are typically requested with the initial referral for 4 units per month and can be increased to as much as 16 units per month.

* Family training should begin immediately following assessment, while waiting for tech to start.

* Training of parents and other family members should take place at least monthly.

* Coach caregivers on data collection, ABA interventions, behavior plans, in-home programs, etc.

* Parent training is not just reviewing progress

* All ABA Treatment Plans should include at least one family training goal.

Transportation by Techs

* Transportation by the person who works with a consumer as a behavior tech is considered by the BACB a dual relationship.
* To avoid this conflict we ask families to provide transportation if possible.
* If providers want to offer transportation services we recommend that a staff person who is not the behavior tech is assigned to do the driving.

Telehealth Services

* Telehealth services for ABA can only be authorized for Supervision (97155) and Parent Training (97156) services.
* Providers should make plan to include at least some in-person time for these services.

ABA Outside of School

* ABA may not take place during typical school hours.
    * Documentation of schedules are needed for school age consumers with more than 15 hours of ABA per week.
* In rare situations the school and family might agree that the consumer would benefit from a reduced school day for a short time. Any request for ABA during this time needs to be written into the IEP with detailed plans and a time limit.

ABA Hours and Medical Necessity

* The recommended number of ABA hours must be medically necessary and based on individual assessments and not by results of the autism evaluation.
  * Minimum hour requirements, which are not feasible standards for many families, are discouraged.
* Evidence shows progress is possible with few hours especially if family training is incorporated.
* The family needs to agree to the schedule.

Dosage Assessment Tool

* This tool is an example of an assessment to objectively determine medical necessity and dosage recommendation.

* The **PEAK** Autism Symptoms and Behavioral Observation Summary (**PAS-BOS**) is part of the PEAK assessment tool created by Mark Dixon and is administered through direct observation to evaluate the frequency and intensity of autism symptoms.

PAS-BOS Tool

The tier scores range from 0-60 and are divided into three tiers in two categories to determine the recommended level of intervention.

Autism Symptoms Frequency of Behaviors	Scale of Intervention Intensity of Behaviors
Tier 1: Client shows minimal or no characteristics of autism	**Tier 1**: Minimal or no ABA treatment is recommended
Tier 2: Client shows characteristics of autism	**Tier 2**: Moderate amount of ABA treatment is recommended
Tier 3: Client shows many characteristics of autism	**Tier 3**: Intensive ABA treatment is recommended

Clinical Judgment

* ADOS testing now is only required every three years
* It is more critical for BCBAs to use their clinical judgment about number of hours and medical necessity to continue ABA
* Disenrollment may occur because:
    * Consumer met goals/no longer medical necessity
    * Family chooses to end ABA or change providers
    * Family does not return calls from provider or case holder
    * Provider chooses to disenroll consumer due to attendance, safety, or other issues

Key Expectations

* Assessments/treatment plans are current, evidence-based, and strength focused.

* ABA schedules are based on medical necessity and family input outside of typical school hours.

* Auths are in place and staff is properly credentialed and trained prior to providing any services.

* Documentation (progress notes, treatment plans, monthly reports) are entered within expected time period.

How Can We Help You?

* ABA Program questions: Mary Schrier (mschrier@cmhcm.org)
* Billing questions: Payables (payables@cmhcm.org)
* Capacity updates: Karen Chapin (kchapin@cmhcm.org)
* CIGMMO Training: Amanda Shanabrook (ashanabrook@cmhcm.org)
* CIGMMO Assignments: Karen Chapin
* Contract questions: Amanda Shanabrook
* Credentialing : Amanda Shanabrook
* Incident Reports: Fax to Dana Jenkins, 1-989-773-1968
* Staffing changes: Amanda Shanabrook & Karen Chapin
* Testing/Evaluations: Mary Schrier & Karen Chapin

THANK YOU!

Questions

&

Answers