

A Response to Papatola and Lustig's Paper on Navigating a Managed Care Peer Review: Guidance for Clinicians Using Applied Behavior Analysis in the Treatment of Children on the Autism Spectrum

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Abstract In their 2016 article, “Navigating a Managed Care Peer Review: Guidance for Clinicians Using Applied Behavior Analysis [ABA] in the Treatment of Children on the Autism Spectrum,” Papatola and Lustig provide an overview of the managed care process, discuss the medical necessity of ABA, and offer guidance to clinicians on how to navigate the managed care peer review process. Given that the authors are employed by a large international health insurance carrier and conduct peer reviews on behalf of that organization, this response seeks to provide guidance from both the clinical and public policy perspectives that reflect best practices in the field of autism treatment. This response is not written with the intention of providing or replacing legal advice; rather, this paper offers health care providers of ABA an essential understanding of some of the laws that govern and support their efforts to secure medically necessary treatment and the mechanisms in place with which to challenge decisions by managed care organizations, health plans, and health insurance issuers that may be contrary to best practices. Finally, suggestions are offered on how to navigate a peer review to ensure optimal outcomes and, when necessary, to lay the groundwork to overturn a funding source decision that does not reflect best practices or the standard of care in ABA-based autism treatment.

Keywords Peer review · Applied behavior analysis · Managed care · Mental health parity · Fail first · Autism

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In their article, Papatola and Lustig's (2016) assert that the “goals for this article are to provide an overview of the peer review process and strategies for more efficient, effective peer review interactions” (p. 135). While we wholeheartedly support their goals, we suggest that they would be more easily achieved by incorporating the balanced perspective we seek to provide here. By the authors' own admissions, their observations and recommendations are based on their experiences “as professionals who conduct per [sic] reviews for a managed care company” (p. 135). In that capacity, contingencies may be in place (i.e., reduction of costs) that may not facilitate best practices or reflect the intent of applicable state and federal laws. Papatola and Lustig state, “While peer reviews...can feel...contentious to providers, they need not be...” (p. 135); we submit that a contentious atmosphere arising from a peer review is a natural product of a meeting in which two professionals seek different outcomes. Precisely because a peer reviewer is unlikely to share the same goals as the ABA provider, the primary goal of this response is to provide balance to the perspective offered by Papatola and Lustig and thereby equip ABA providers with sufficient knowledge to prevail in their efforts to secure medically necessary treatment for their patients. A secondary goal of this response is to demonstrate the importance of ensuring that the practice of ABA be informed by behavior analysts, rather than funding entities.

Origins of the Managed Care Peer Review

Papatola and Lustig begin with a brief summary, absent citations, of the “Origins of the Managed Care Review” (p. 136). They describe the rise of managed care to control costs in an environment in which “there were few guidelines for effective treatment and even fewer practice parameters shared industry wide” (p. 136). The authors describe a situation in which

“clinicians had been free to treat their clients using treatment modalities, of their own choosing, for whatever length of time the clinician deemed appropriate – regardless of outcome” (p. 136). Papatola and Lustig’s (2016) implication that the increased scrutiny by managed care organizations (MCOs) was a response to arbitrary clinical decision-making and that physicians were not used to such **scrutiny** disregards the evidenced-based nature of the practice of medicine, which certainly involves significant scrutiny and the adherence to professional and ethical oaths that mandate clinicians in a myriad of ways to make treatment recommendations that contemplate potential outcome. It is difficult to accept the authors’ premise of a time when clinicians wholly disregarded outcome, and it is unfortunate and unnecessarily alienating that this characterization lays the authors’ foundation for the rise of managed care as the responsible parent coming to the rescue of clinical practices run amok. Perhaps, the authors meant to convey that clinicians had not previously been accustomed to the *insurance industry* questioning the medical necessity of treatment. In fact, managed care organizations arose to *manage care*. That is, managed care is the product of financial—not clinical—concerns (Kesselheim, 2001). While cost containment is a necessary consideration in health care, the cost-effectiveness of medically necessary treatment is separate and distinct from the determination of whether and which treatment is medically necessary. For that reason, MCOs may consider financial variables that clinicians rightly do not, especially given the fact that there is no equally effective alternative to ABA in the treatment of ASD (Eikeseth, 2009; Myers & Plauche Johnson, 2007).

Prior to the emergence of managed care organizations, health insurance entities regularly conducted retrospective reviews as part of the reimbursement process and in place of the prospective utilization reviews that are more common today (Hall & Anderson, 1992; Bergthold, 1995). In the 1980s, problems had arisen with retrospective reviews, whereby families incurred the financial burden of health care services despite having received the treatment at the direction of their physician (Andresen, 1998; Hall & Anderson, 1992). Often, disputes were settled in court, with a pattern of loss on the part of the insurer (Hall & Anderson, 1992). Incorporating prospective reviews and including “medical necessity” in contracts were attempts to circumvent this problem (Hall & Anderson, 1992). The prospective utilization review process subsequently became a standard process for Medicare and employer-funded plans (Hall & Anderson, 1992). Private insurance began to favor the prospective reviews for these reasons and, most importantly, as a cost-containment measure (Andresen, 1998; Hall & Anderson, 1992; Kesselheim, 2001). MCOs became even more appealing, incorporating new rules, organizational controls, limited options to health care providers, and, at times, financial incentives for modifying health care providers’ behavior (Kesselheim, 2001). An

increase in the peer review process was among these strategies. As a result, the MCO reviewer, whose employment relies on the MCO’s continued profitability, was placed in a position to challenge the medical necessity of clinical recommendations and potentially make decisions that reduce, deny, or otherwise alter the clinical recommendations of the health care provider.

The Review Process

In this section, Papatola and Lustig provide useful insight into the authorization process from the MCO perspective (p. 136). For example, initial or ongoing authorization of treatment may require a *clinical review* with a “professional representative” (p. 136). If questions remain after the clinical review, “the case is often referred for a peer review” (p.137). The authors describe the statutory time constraints that may drive the scheduling of the peer review and suggest that the “provider...has the option of ‘stopping the clock’ by withdrawing the request for services” (p. 137). They characterize this option favorably, saying, “...the timing of the review can be more thoughtful and the provider is afforded more time to prepare,” adding, “There are no penalties for invoking this option” (p. 137). Although the concept of a leisurely preparation period may be attractive, clinicians should avoid stopping the clock whenever possible. Time constraints exist to protect patients by ensuring timely access to medically necessary treatment (45 CFR § 147.136). That burden is squarely on the MCO or other funding entities, and clinicians who understand the medical necessity of ABA in the treatment of autism and whose clinical practices reflect the standard of care are unlikely to benefit from stopping the clock. Additionally, clinicians who stop the clock may be depriving their patients of timely access to medically necessary services, and research has certainly demonstrated that patients who receive treatment earlier are more likely to have better outcomes (Bibby, Eikeseth, Martin, Mudford, & Reeves, 2002; Fenske, Zalski, Krantz, & McClannahan, 1985; Harris & Handleman, 2000).

Papatola and Lustig assert that “lack of preparation is one of the most common reasons cases are sent to peer review” (p. 137). In our experience, peer reviews occur because the supervision and/or therapy hours a clinician requests are greater than those recommended by the funding source; the locations of service delivery are viewed unfavorably by the funding source; and/or as a routine part of the authorization process. Since those variables are unlikely to change over the course of a few weeks, it is rarely beneficial or advisable for the ABA provider to stop the clock. To Papatola and Lustig’s point, if a clinician is unprepared for the initial clinical review, we would encourage the clinician to consider seeking additional support and/or mentorship.

Medical Necessity

Papatola and Lustig begin their section on medical necessity by stating, “In order for health-care services to be covered under a health plan, they must be determined to be medically necessary as defined by the plan” (p. 137). In fact, this is not the case, although it may reflect what commonly occurs in practice. The statement as asserted, though, is inaccurate, as it suggests a health plan covers only those services that have been identified “by the plan” as being medically necessary (p. 137). Services that a plan may have initially determined not to be medically necessary are routinely authorized when those determinations are challenged, either through a peer review process or through the appeals process. Federal law requires that group health plans and health insurance issuers, including MCOs, “implement an effective internal claims and appeals process” to ensure that individuals and their clinicians have the ability to appeal a plan’s determination of whether a service is medically necessary (29 CFR §§ 2590.715–2719; 45 CFR § 147.136). Consequently, it is important for clinicians to understand that medical necessity is only *initially* determined by the funding source; and that a plan’s definition of medical necessity should only serve to inform a clinician about the plan’s perspective and should not influence the clinical decisions that are made based on the clinician’s professional judgment derived from clinical experience, patient observation, and understanding of best practices.

Historically, health plans and health insurance issuers characterized ABA as *experimental* or *educational* and used that classification to exclude ABA as a covered benefit for autism spectrum disorder (Stuart, 2011). With the proliferation of autism insurance reform (i.e., autism mandates) in all but a handful of states, ABA has been deemed a medically necessary treatment for ASD. As a result, once coverage of ABA is verified, denials of ABA-based autism treatment must be based on a lack of medical necessity, which is complicated by the fact that no single definition of medical necessity is used to guide these determinations.

Papatola and Lustig (2016) reference the origin and history of *medical necessity*, absent any citations, and bemoan clinical practices that are bereft of a definition of medical necessity that would give badly needed clarity to clinicians who, they say, use medical necessity “as a prompt...to the third-party payer...” (p. 136). The concept of “medically necessary care” was first raised in 1965 by Congress as a stipulation of care to Medicaid recipients (Callahan, 1991; Hall & Anderson, 1992). Medical necessity was later defined in case law and state laws in the 1970s (Bergthold, 1995; Callahan, 1991). Unfortunately, attempts to codify definitions of medical necessity in state law have been and continue to be strenuously opposed by the insurance industry (Bergthold, 1995). Rather, health plans promulgate their own definitions of medical necessity which may fall short of a clinician’s view of best

practices (Bergthold, 1995). Papatola and Lustig (2016) opine that “...the term remains an enigma to many practitioners because it cannot be defined in a single sentence, but rather as a group of characteristics that must be met in order to qualify for usage of the term” (p. 136). The authors’ reference to a “group of characteristics” appears to describe the medically necessary criteria that are often delineated in the policies of MCOs and other funding sources. A review of these criteria reveals, however, that some “characteristics” may violate the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), a federal law that “...generally requires that group health plans and health insurance issuers...ensure that the financial requirements and treatment limitations on Mental Health...benefits...are no more restrictive than those on medical or surgical...benefits” (U.S. Department of Labor & Department of Health and Human Services, 2016). Examples of criteria that may violate MHPAEA include hour limits, treatment plan requirements, and parent/caregiver participation requirements, to name a few. Because MCOs are among those organizations subject to MHPAEA, clinicians would be wise to consider a funding source’s medically necessary criteria as a reflection of the funding source’s understanding of autism treatment and not as rules that govern the ABA provider’s practice of ABA.

Strategies for Effective and Efficient Peer Reviews

Papatola and Lustig’s stated purpose in this section is to bring clarity to “areas of misunderstanding or object disagreement that are present frequently during a peer review for coverage of ABA” (p. 138). In the subsections, they describe a specific area in which reviewers (according to Papatola and Lustig) encounter challenges with clinicians, and they present vignettes in which a seemingly incompetent clinician is guided by the wisdom of a highly informed reviewer, concluding with recommendations to maximize a clinician’s opportunity for success during a peer review process. The language of the reviewer in what the authors describe as actual peer reviews is markedly more professional than the quotes attributed to the “provider,” which has the unfortunate effect of depicting the clinician as a hapless provider who is interacting with a highly skilled and well-informed health plan representative (p. 136). The authors state that the reviews are “generally conducted by clinicians working for the MBHCO [managed behavioral health care organization]” (p. 137). In our experience with dozens of MCOs and health plans, peer reviewers are rarely true *peers* in the sense of sharing similar professional experience and education. Most health plan representatives who conduct peer reviews seem to have limited knowledge about ABA, autism, or the patient whose services are being reviewed. Although some clinicians may be inadequately prepared to answer questions during the peer review, a peer

review in which the health plan representative is more knowledgeable than the clinician about the patient's autism treatment is rare enough that we have not, yet, experienced it. To be sure, any good provider would welcome a highly informed and educated peer reviewer who is an expert in ABA and autism and has actually thoroughly reviewed a patient's history, treatment, progress, deficits, and behaviors.

Occupational labels aside, ABA providers should be acutely aware of the fact that they do not likely share a common goal or a common role with the peer reviewer. Our purpose here is not to denigrate the reviewers at the MCOs; rather, it is to clarify the role that they are actually intended to play and to clarify the role of the ABA provider. We contend that the background of the MCO reviewer is not—as the title might intimate—one of a true peer whose knowledge of ABA and autism treatment is on a par with the ABA provider. Moreover, the goal of the peer reviewer is considerably different than the goal of the ABA provider; that is, while the clinician's goal is to treat the patient's symptoms of ASD, the MCO reviewer has a goal of reducing and minimizing costs, acting as a fiscal gatekeeper to minimize expenses beyond what his or her employer is legally required to provide (Hall & Anderson, 1992). Clinicians, therefore, should approach the peer review process with the knowledge that they are advocating for their patient's medically necessary treatment, and their role is likely at cross purposes with the goal of the peer reviewer.

Diagnosis

We firmly agree with Papatola and Lustig's statement that clinicians must operate within their scope of practice (p. 138) and that for most behavior analysts, that does not include functioning as diagnostician. (It should be noted, some behavior analysts hold the credentials to be qualified to diagnose.) We also agree with their recommendations that clinicians have access to and be familiar with the diagnosis, including knowledge of when and by whom the diagnosis was made and that it is current relative to the plan guidelines. However, Papatola and Lustig cite the "DSM-V" [sic] as a "required" component "to properly evaluate medical necessity" (p. 137). The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013) explicitly provides instructions for those who have a *DSM-IV* diagnosis, stating, "Individuals with a well-established *DSM-IV* diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder." Additionally, the *DSM-5* specifically states, "Because symptoms change with development and may be masked by compensatory mechanisms, the *diagnostic criteria may be met based on historical information* [emphasis added]..." (pp. 31–32). Certainly, the publication of the *DSM-5* was not

intended to render existing diagnoses moot or to imply that those with a *DSM-IV* diagnosis no longer have symptoms of autism that require medically necessary treatment. To be clear, the fact that a patient has a diagnosis based on the *DSM-IV* is not a basis for denial, although it may be a reason for a funding source to authorize an updated diagnostic evaluation and/or report. If a clinician is confronted with a health plan denying services because a patient has a *DSM-IV* diagnosis, the clinician should consider appealing that denial and asking for services to be authorized while the diagnosis is updated.

History

Papatola and Lustig suggest behavior analysts do not take into account factors beyond the immediate and observable environmental factors (p. 139). In fact, practitioners of ABA "solicit and integrate information from the client and family members and coordinate care with other professionals" (Behavior Analysis Certification Board, 2014, p. 6). To exemplify this, a clinician may alter treatment modalities for a patient with a history of specific traumas, a patient who is taking certain medications, or a patient with a chronic medical condition, just to name a few examples. Contrary to Papatola and Lustig's claim, behavior analysts do take into account a myriad of factors in treating their patients, which may include the patient's history, temporally distant events, or events that are not directly observable. While coordination of care and knowledge of a patient's history are important, peer reviewers should limit their questions to those factors that affect the patient's ABA treatment. All too often, a peer reviewer asks the ABA provider to explain the purpose of a medication prescribed by the patient's physician or inquires about treatment provided by a physician. When a peer reviewer's questions pertain to elements of a patient's treatment not overseen by the ABA provider, the clinician should not hesitate to point out that the question is outside of the clinician's area of expertise and encourage the peer reviewer to direct such questions to the appropriate provider. At the same time, clinicians should try to steer the conversation back to the deficits and behaviors that the clinician is treating.

Use of Standardized Measures in Diagnosis and Assessment of Function

In this section, Papatola and Lustig state "most MBHCOs want to ascertain that tools in use are valid (i.e., actually measure what they claim to measure) and reliable (i.e., that they do so consistently over time). The use of standardized instruments helps reassure consistency of meaning when discussing outcomes" (p. 140). We agree with the importance of valid and reliable measures. However, for the purpose of establishing baseline for specific responses, current behavior analytic practices are the most appropriate, valid, and reliable, and do

not require psychometric standardization. Behavior analysts have procedures to ensure validity and reliability. Developing technical and objective behavioral definitions, assessing and ensuring interobserver agreement and procedural integrity, and employing experimental designs are best practices in ABA that best validate the methodologies recommended by the clinician. Making use of standard behavior analytic methodologies ensures that the behavior being evaluated would be assessed in the same way by other competent behavior analysts, that their results would yield similar outcomes, and that the change in behavior is due to the intervention and not something else. For the purpose of the job behavior analysts are employed to do, industry standard behavior analytic practices and procedures are most appropriate (e.g., functional analyses, Iwata, Dorsey, Slifer, Bauman, & Richman, 1994; Verbal Behavior Milestones Assessment and Placement Program, Sundberg, 2008). If MCOs require anything other than standard behavior analytic services/procedures, those assessments should be conducted by the appropriately qualified individuals. To be clear, we are not claiming that there is no place for standardized assessment tools, just that the authors' inference that standard behavior analytic practices are insufficient and that failure to use standardized assessments could justify a denial is incorrect.

Necessary Elements of a Treatment Plan

Papatola and Lustig list “four major elements needed for a treatment plan,” including “design and supervision of plan” by an appropriately credentialed clinician, treatment targets, parent/caregiver participation, and a plan for fading services and discharging the patient. Perhaps, the most important information to impart in relation to the treatment plan is that the clinician develops the treatment plan as a *best practice* to ensure others can implement the procedures as intended. Recent sub-regulatory guidance on mental health parity from the United States Departments of Labor and Health and Human Services (2016) indicates that the requirement of a treatment plan as a *condition* of authorization of medically necessary treatment “can serve as a red flag that a plan or issuer may be imposing an impermissible NQTL [non-quantitative treatment limit].” That is, treatment plans represent a clinical best practice, but MCO and insurer policies that require providers to (a) submit treatment plans to the MCO or insurer, (b) include specific elements in the treatment plans, and/or (c) use specific treatment plan templates as a *condition of authorization* of medically necessary treatment likely violate the MHPAEA and, therefore, may represent improper requirements on the part of the MCO or insurance entity. While we welcome such clear federal guidance wholeheartedly, clinicians should be cautious in using this guidance to challenge an MCO policy that requires the treatment plan as a condition of authorization. Historically, such guidance will

require strategic efforts to increase awareness and prompt enforcement before MCOs, health plans, and health insurance issuers routinely comply. In response to an MCO's effort to dictate the contents of a treatment plan or to require the use of a specific treatment plan template, we encourage clinicians to provide the federal guidance to the MCO with a respectful request that the MCOs act in accordance with that guidance (Department of Labor & Department of Health and Human Services, 2016). In the face of a noncompliant MCO, we cannot in good conscience assert that you will be successful in shaping the MCO's behavior and recognize that clinicians may need to comply with errant requests as this new guidance takes hold.

Goal Setting and Tracking Progress

In this section, the authors demonstrate exactly why an MCO's involvement in a clinician's treatment plan likely violates MHPAEA. Under MHPAEA regulations, “...any processes, strategies, evidentiary standards, or other factors [must be] comparable to, and are applied no more stringently than, those used...with respect to med/surg benefits...” (Department of Labor & Department of Health and Human Services, 2016). Setting aside the MHPAEA issue, consider the topics that are addressed in this section. Most of the discussion centers around how to determine when a patient should be discharged, despite the fact that “Discharge” has its own section. Again, recognizing the reviewer's role as fiscal guardian of the MCO, this limited perspective on the treatment plan as a tool with which to fade services is understandable. The omission of any discussion about how to identify and prioritize treatment goals and the importance of linking those goals to diagnostic criteria should serve as reminders to clinicians that a peer review is a misnomer, and ABA providers should continuously be cognizant of the fact that they do not share common cause with the peer reviewer.

Papatola and Lustig (2016) preface their vignette in this section with a concern about the “lack of a standard definition for ‘progress’ or ‘gains’” and state, “There is no operational definition for the word ‘enough’ when referring to behavioral changes for children on the spectrum” (p. 141). In actuality, these concerns belie the data-driven nature of behavior analysis that ensures that progress is tracked and new goals are set as earlier goals are reached. Furthermore, the behavior analyst clearly and objectively defines specifically what qualifies as progress for each individual patient. Unlike the murkiness that clouds this subject for Papatola and Lustig, discharge is clearly appropriate when treatment is not medically necessary, i.e., an individual no longer benefits from treatment. Furthermore, the authors group “less than sufficient resources” with lack of progress in their summary of reasons to fade services (p. 142). Rather than fade services, an ABA provider who lacks sufficient resources to treat a patient may refer the patient to

another provider in the event that resources remain insufficient, but a provider's ability—or inability—to provide treatment has no bearing on whether that treatment is medically necessary. Beyond providing a generic description of the criteria that must be met in order to fade treatment, it is the view of these authors that no ABA provider should be asked—or should feel compelled to accommodate a request—to provide patient-specific discharge criteria when a patient displays deficits and behaviors associated with his or her diagnosis of ASD.

Parent Training

Papatola and Lustig identify parent/caregiver participation as one of the four areas needed for a treatment plan (p. 141). When parents do not participate, they suggest, “ABA may not be the most appropriate nor the most effective method for every child that presents for treatment. Other treatments that require less parent time may be more suitable” (p. 142). They further state “lack of compliance with this parameter accompanied by marginal expectations for parent participation and training is a common reason for which cases are referred for a peer review, and not uncommonly leads to the denial of benefit coverage.” (p. 142). Although the BACB emphasizes the importance of parent training (BACB, 2014), and research has shown that parent training contributes to effective treatment (Strauss, Mancini, & Fava, 2013), parent/caregiver participation *may not* be a *prerequisite* to or *condition* of treatment. To deprive a child of medically necessary treatment because of a parent's failure or inability to participate in the treatment violates, where applicable, Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, the Mental Health Parity and Addiction Equity Act (MHPAEA), and the Americans with Disabilities Act (ADA). To put it in starker terms, imagine a child with asthma who is not given medically necessary treatment because his parent refuses to stop smoking. The fact that a parent smokes in a home with an asthmatic child has nothing to do with the medical necessity of treating the child's asthma, and it would be improper for a health plan to deny medically necessary treatment for the child on the basis of the parent's behavior. The same is true for ABA: a parent's ability or willingness to participate in treatment has nothing to do with the medical necessity of the treatment and, therefore, is not a basis on which a health plan should deny or reduce treatment hours (other than those hours designated for parent/caregiver training).

Despite the benefits and efficacy of parent training, there may be various reasons parent training does not take place. For example, parents may have other obligations that conflict with the time necessary to participate in parent training. Additionally, parents may have mental or physical disabilities themselves that make participation in the treatment plan

extraordinarily challenging. It may also be the case that parent training is not necessary to achieve the targeted objectives and that based on a needs assessment conducted by the behavior analyst, parent training objectives are not clinically indicated.

Where parent training is clinically indicated but the parent is unwilling or unable to participate, clinicians should be sure the parent understands the potential impact of his/her participation—or lack thereof—on the child's outcomes. In addition to presenting the benefits of parent training, clinicians may develop strategies to encourage participation in parent training programs. Whenever possible, a clinician's efforts to involve parents/caregivers and challenges that arise should be documented in the treatment plan. However, as outlined above, a parent's non-participation should not preclude a child from receiving medically necessary treatment because such a policy is a violation of MHPAEA and because ABA is still extremely effective without parent participation (California Health Benefits Review Program, 2016).

Discharge Criteria

Papatola and Lustig raise a straw man in their effort to justify explicit discharge criteria, describing behavior analysts who never want to discharge their patients. The simple—and sad—fact is that the prevalence rate of autism (Center for Disease Control [CDC], 2014), coupled with the shortage of clinicians (Sema et al., 2015), gives even the bumbling clinicians with whom Lustig and Papatola have apparently interacted no motivation to hold onto a patient who is no longer benefiting from treatment. We commend Papatola and Lustig for asking an important question; specifically, the authors ask, “For what other clinical conditions characterized by severe behavioral manifestations, do we expect *all goals* to be met before considering discharge, especially when those goals require such significant change that the child would appear to be typically developing?” (p. 143). If we ask that same question but remove “characterized by severe behavioral manifestations,” we are challenged to think of a clinical condition for which treatment is discontinued when symptoms persist and treatment remains beneficial. For example, would we discontinue kidney dialysis before kidneys are able to function effectively? Are the authors suggesting that individuals who require mental health services should have different discharge criteria than those who require medical/surgical services? Of course, to impose restrictions on mental health services that are not imposed on substantially all other medical/surgical services violates MHPAEA, which clearly applies to managed care organizations.

Another practice that likely violates MHPAEA is the effort to transition medically necessary treatment from a qualified health care professional, such as a behavior analyst, to the parent or caregiver. Papatola and Lustig ask, “Can there be room for operationally defining behavior change that

constitutes enough progress to warrant discharge from the direction of the BCBA and into the hands and direction of parents and caregivers?" The fact that the authors phrase this concept as a question, rather than a statement, is telling in and of itself; imagine if a national health plan had a formal policy in place of transferring medically necessary treatment to parents and caregivers.

Papatola and Lustig state in their summary that "discharge (or termination) is a misnomer. It is better described as transitioning the program from the therapist to the parents

and the community" (p. 145). While parents, siblings, and caregivers may have the potential to supplement medically necessary treatment, clinicians who provide medically necessary treatment are not training parents to take over the role of providing medically necessary treatment. Is kidney dialysis transferred to parents and caregivers? Of course, the answer is no. Yet, insurance carriers, health plans, and administrators have recently tried to define the goal of autism treatment as shifting the medically necessary treatment from a nationally certified, often licensed, highly trained, and experienced

Table 1 Preparing for a peer review

Area	Strategies
Basic client/patient information	<ul style="list-style-type: none"> • State the exact diagnosis, the date the diagnosis was made, and the name and credentials of the diagnostician.
Treatment goals and recommendations	<ul style="list-style-type: none"> • Relate treatment goals to diagnostic criteria. For example, teaching Jimmy to say "hi" to his classmates should be a sub-heading under "Social Communication and Social Interaction Deficits." • When necessary, describe patient deficits and treatment goals using language that a peer reviewer who has limited or no background in ABA can understand. • Cite research that supports your recommendations. • Repeatedly state your professional justification for the treatment authorization you seek. • Discuss any comorbid diagnoses and the extent to which they affect or do not affect the patient's ability to participate in treatment. • Have corresponding data to support recommendations. • Explain that services provided by a school to comply with the school's obligation to deliver a Free Appropriate Public Education (FAPE) do not rise to the health plan's duty to authorize medically necessary treatment and, as such, may supplement but rarely supplant medically necessary treatment hours. • Establish that the services that are being recommended are not duplicative of other services.
Progress reporting	<ul style="list-style-type: none"> • Describe progress, explain treatment plateaus or regression, and reiterate the deficits and behaviors that continue to require ABA.
Parent training	<ul style="list-style-type: none"> • Share your strategy for getting/keeping the parents/caregivers involved in treatment. These may include efforts to make parents aware of research that demonstrates the benefit of parent participation or offering parent training during non-traditional work hours or via the internet.
Coordination of care	<ul style="list-style-type: none"> • Discuss your efforts to coordinate care with other health care providers and funding agencies. If a family does not authorize you to communicate with other providers, be prepared to describe the ability for treatment to be effective and the certainty that it is not duplicative, regardless of coordination of care. For example, the number of hours that a child should receive ABA is not likely impacted by other services s/he may receive, such as speech or occupational therapy.
Discharge criteria	<ul style="list-style-type: none"> • Share boilerplate/generic language that summarizes the criteria that would prompt you to fade and then terminate services. This can be as simple as "when all treatment goals are met and the patient can no longer benefit from treatment."
General tips	<ul style="list-style-type: none"> • Politely point out any instances when the peer reviewer raises concerns that disregard governing law. For example, if the health plan says the patient is too old to benefit from ABA, you might be able to say your state mandate has no age limit. • Take notes. If a denial letter does not include the same points that are made during a peer review, you may want to reference the peer review notes if you appeal the result. • Redirect the peer reviewer who strays off topic. If asked specific questions about medications, for example, suggest that the peer reviewer direct questions about medication to the prescribing physician and refocus the conversation to address the treatment you provide and why it is medically necessary for the patient to receive that treatment. • State the credentials of everyone on the insured's ABA treatment team.

clinician to a parent. As described earlier, rather than characterize a discharge plan as when “all goals have been met,” as Papatola and Lustig describe in their caricature of a behavior analyst, a clinician’s single discharge criterion should reflect that services will be faded and then terminated when a patient no longer benefits from treatment.

Preparing for a Review

A clinician’s preparation is an important aspect of the peer review process, if only to lay the groundwork for a strong appeal in the face of an adverse outcome. Strategies for preparing for a peer review are included in Table 1. Clinicians who require more comprehensive guidance are encouraged to seek mentorship in the field, review published articles and reports, and take advantage of professional development opportunities to expand their knowledge of insurance processes as they relate to ABA.

Discussion

In this response to Papatola and Lustig (2016), we address several inaccuracies and misrepresentations as presented by the authors, clarify some of the laws that govern insurance-funded, medically necessary autism treatment, and offer suggestions based on those laws to help behavior analysts preserve clinical best practices while navigating the managed care peer review process.

Going forward, behavior analysts should continue to work together to develop and disseminate best practices and to ensure that MCOs, health plans, and health insurance issuers facilitate those best practices with policies that reflect the state and federal laws and regulations intended to ensure access to medically necessary ABA. Compliance with Medicaid EPSDT requirements, autism mandates, and state and federal mental health parity laws varies broadly from state to state and from one funding source to the next. Until compliance is achieved across all states and all funding sources, potential exists for behavior analysis to be adversely influenced by improper guidelines of MCOs, health plans, and health insurance issuers. The field should be alert to policies and practices that disregard or contradict prevailing treatment research, and behavior analysts should continue to work collaboratively with all stakeholders to ensure that ABA is not diluted by improper or misguided policies and practices.

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