

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES



AUTISM SPECTRUM DISORDER (ASD) SERVICES PROVIDER MANUAL

JULY 1, 2026

South Carolina Department of Health and Human Services

DRAFT

CONTENTS

1. Program Overview	1
2. Covered Populations	2
• Eligibility/Special Populations	2
3. Eligible Providers	3
• Provider Qualifications.....	X
• Provider Qualification Table.....	X
4. Covered Services and Definitions	X
• Covered Services and Definitions	X
• Non-Covered Services	X
5. Utilization Management	X
• Prior Authorization	X
6. Reporting/Documentation.....	X
• Additional Program Requirements	X
7. Billing Guidance.....	X
8. Benefit Criteria and Limitation	X

1

PROGRAM OVERVIEW

The South Carolina Department of Health and Human Services (SCDHHS) oversees the provision of autism spectrum disorder (ASD) services delivered to Healthy Connections Medicaid members via the following programs:

- Fee-for-service (FFS)
- Managed care organization (MCO)

The ASD Services Provider Manual supplements SCDHHS's general policies and procedures detailed in the Provider Administrative and Billing Manual and it provides policies and requirements specific to ASD services providers for the FFS program. For services delivered to MCO members, providers must follow the member's MCO's policies and requirements.

The purpose of this manual is to provide pertinent information to ASD service providers for participation in the South Carolina Medicaid program. Providers must review, reference, and comply with both the ASD Services Provider Manual and the Provider Administrative and Billing Manual.

Note: References to supporting documents and information are included throughout the manual. This information is found at the following locations:

- [Provider Administrative and Billing Manual](#)
- [Forms](#)

2

COVERED POPULATIONS

ELIGIBILITY/SPECIAL POPULATIONS

Eligibility for Services

Medically necessary services to treat ASD are provided to eligible Medicaid members age 0 through 20 years (up to the last day of the month of the member's 21st birthday) who have:

1. A diagnosis of ASD that meets criteria from the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders at the time of the initial assessment; or
2. An Individuals with Disabilities Education Act (IDEA) designation that meets the South Carolina Department of Education standard for the disability category of ASD and has been confirmed by a physician involved with the member's care; or
3. An eligibility determination under the autism category from the South Carolina Department of Behavioral Health and Developmental Disabilities (BHDD) Office of Intellectual and Developmental Disabilities (OIDD) and has been confirmed by a physician involved with the member's care.

Additionally, in accordance with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, eligible members at risk for the development of ASD are presumptively eligible for applied behavior analysis (ABA) therapy services when this risk is determined through IDEA Part C and/or the risk is documented within the medical care home by a physician.

Verifying Member's Eligibility

Participating Healthy Connections providers must access member eligibility information through the SCDHHS' Web Portal or Customer Service Center. Members must be eligible on the date of service for payment to be made.

Providers must verify current eligibility and third-party liability (TPL) status prior to service delivery. Gaps in Medicaid eligibility may result in a referred member being ineligible for Medicaid coverage at the time of treatment.

3

ELIGIBLE PROVIDERS

PROVIDER QUALIFICATIONS

To participate in the South Carolina Healthy Connections Medicaid program, providers must be enrolled as a licensed independent provider (LIP) or a board-certified behavior analyst – doctoral level (BCBA-D), board-certified behavior analyst (BCBA) or board-certified assistant behavior analyst (BCaBA). An eligible provider will maintain a written participation agreement in effect with SCDHHS to provide ASD services to members enrolled in the Healthy Connections program pursuant to the South Carolina State Plan for Medical Assistance and in accordance with Title XIX of the Social Security Act, as amended. As it relates to delivery of ASD services, a Medicaid-enrolled provider will be referred to as an “ASD provider”.

ASD providers must meet all applicable Medicaid provider qualifications, including state licensure and/or certification regulations specified by the state licensing authority (when applicable). ASD providers must follow state and federal laws, rules and regulations. ASD providers delivering or supervising ASD services must conform to the scope of practice as indicated by their respective licensing and/or certification boards.

Except as required by 42 CFR 431.52, providers of ASD services must be located within the South Carolina Medical Service Area (SCMSA) to ensure (i) quality care is delivered based on clinical standards, (ii) the full covered service array under the behavioral health benefit is available to the member, and (iii) each member has access to in-person care whenever necessary.

Enrolled providers are prohibited from using their National Provider Identifier (NPI) to bill Medicaid for services rendered by a non-enrolled, terminated or excluded provider. The non-enrolled policy provision does not apply when providers deliver services under their supervision.

For general information regarding provider qualifications and enrollment in the South Carolina Healthy Connections Medicaid program please refer to the Provider Administrative and Billing Manual and to [SCDHHS's website](#).

The following practitioners are allowed by South Carolina state law to enroll directly with the Medicaid program and provide ASD services:

- Licensed psychologist
- Licensed psycho-educational specialist (LPES)
- LISW - Clinical Practice (LISW-CP)
- Licensed marriage and family therapist (LMFT)
- Licensed professional counselor (LPC)

- BCBA-D
- BCBA
- BCaBA

Provider Qualification Table	
Credential	Provider Qualifications
BCBA-D	<p>BCBA-D is the doctoral designation for a BCBA with doctoral training in behavior analysis.</p> <p>BCBAs supervise the work of BCaBAs, registered behavior technicians (RBTs) and others who implement behavior-analytic interventions.</p>
BCBA	<p>A BCBA has a graduate-level certification in behavior analysis. BCBAs supervise the work of BCaBAs, RBTs and others who implement behavior-analytic interventions.</p>
BCaBA	<p>A BCaBA has an undergraduate-level certification in behavior analysis. BCaBAs must be supervised by someone certified at the BCBA-D/BCBA level.</p> <p>BCaBAs can supervise the work of RBTs and others who implement behavior-analytic interventions.</p>
RBT	<p>An RBT is a paraprofessional who practices under the supervision of a BCBA-D, BCBA or BCaBA. The RBT is primarily responsible for the direct implementation of behavior-analytic services. The individual supervising the RBT is responsible for the work performed by the RBT.</p> <p>Must be 18 years of age or older, possess a minimum of a high school diploma or national equivalent, complete 40 hours of training, pass the RBT Competency Assessment and pass the RBT exam.</p>
Behavior Technician	<p>A paraprofessional who practices under the supervision of a BCBA-D, BCBA or BCaBA. The behavior technician (BT) is primarily responsible for the direct implementation of the behavior-analytic services. The individual supervising the BT is responsible for the work performed by the BT. Must be 18 years of age or older and possess a minimum of a high school diploma or national equivalent. Technicians will be granted a one time, 90-day period to acquire an RBT credential from the first date of</p>

	<p>providing services to Medicaid members. The 90-day period does not reset if the BT’s employment status changes, or if the BT does not obtain their RBT credential. Any services delivered by the BT after the expiration of the 90-day period and without obtaining their RBT credential, will be subject to postpayment review and recoupment from the enrolled provider whom the services were billed under. Due to the complexity of service provision in home and school-based service locations, and to ensure they have access to necessary supervision. Uncredentialed BTs are only authorized to provide services in clinic-based service locations during the 90 day grace period and only when a BCBA is on site and available to provide any necessary professional and clinical supervision.</p>
<p>Licensed Psychologist LPES LISW-CP LMFT LPC</p>	<p>Please see the LIP Rehabilitative Services Manual for LIP provider qualifications.</p>

Additional ASD Provider Enrollment Guidelines

The Centers for Medicare and Medicaid Services (CMS) strengthened requirements for Medicaid provider screening to prevent fraud, waste and abuse. CMS requires state Medicaid agencies to screen all provider applications based on a categorical risk level of “limited,” “moderate” or “high.” This categorization helps the agency align with federal requirements and ensures taxpayer funds are appropriately safeguarded.

When a state Medicaid agency designates a provider type as a “high” categorical risk, the agency must require fingerprint-based criminal background checks (FCBC) for providers and any entity with 5% or more direct or indirect ownership interest in the provider. The agency can also require FCBC for any provider type regardless of categorical risk level. As such, newly enrolling ASD providers must undergo level one and level two FCBC with both the South Carolina Law Enforcement Division (SLED) and the Federal Bureau of Investigation. All individual ASD providers must complete the FCBC during the ASD provider enrollment process.

Groups of ASD providers (i.e., ASD providers linked to and practicing under an enrolled group) are included in the “high risk” category and as such are required to comply with the CMS regulations (42 CFR Part 455 subpart E) associated with this category. Additionally, it is vital that provider owners and managing employees understand that they can be held criminally liable for the actions of the providers’ employees, agents, and representatives.

In addition to the FCBC, requirements for enrollment as a “high risk” provider include the following steps:

- Must undergo a pre-enrollment site visit.
- May undergo a post-enrollment site visit to verify that the information submitted to SCDHHS is accurate and to determine compliance with federal and state enrollment requirements. (§ 455.432[(a)]).
- Must provide 100% disclosure of ownership to the grandparent level and attest to the disclosure of ownership during the provider enrollment process in accordance with CFR 42 §455.102.

Note: In accordance with S.C. Code Ann. §40-75-290 (Supp. 2023, as amended), the above requirements do not apply to state agency providers, mental health counselors who are school district employees, or entities acting on behalf of a state agency, including child-placing agencies and developmental evaluation centers.

Maintenance of ASD Network Provider Credentials

All ASD network providers must be properly qualified and trained and must comply with all applicable State, federal and board requirements that adhere to their scope of competency. Additionally, ASD network providers must comply with all applicable federal and state Medicaid regulations in the provision of services to both FFS and MCO members.

ASD network providers must maintain and make available upon request, appropriate records, and documentation of such qualifications, training, certifications and credentials.

All Medicaid-enrolled provider groups must maintain a file substantiating each individual provider's qualifications and training, for at least seven years from the date of service as directed by the BACB; including all current and past providers who delivered any ASD service. Employer files must include employer verification of the ASD provider's license and/or board certification and work experience, including details of the outcomes of the one-time 90-day grace period for all uncredentialed BTs who delivered services. The group must maintain a signature sheet that identifies all professionals providing services by name, signature, credentials and initials.

In addition to documentation of ASD network provider credentials and training, the provider group must keep the following specific documents on file for all provider levels:

- A completed employment application form.
- Copies of advanced degrees.
- A copy of all applicable licenses or board certifications.
- Letters or other documentation of verification of previous employment/volunteer work to document experience with the population to be served.

- Documentation of compliance with all state and federal health and safety regulations.
- A copy of the individual's criminal record check from SLED.

Note: The SLED check must be updated annually.

- Evidence of child abuse registry checks completed prior to the start of employment and annually thereafter.
- Evidence of state and national sex offender registry checks completed prior to the start of employment and annually thereafter.
- Evidence of child abuse and state/national sex offender registry checks must not indicate any findings and/or criminal charges against an individual.

LIPs must be licensed to practice in the state where they are providing services if located within the SCMSA and must not exceed their licensed scope of practice under appropriate State law.

ABA providers must be located within the South Carolina Medical Services Area (SCMSA), be certified by the Behavior Analysis Certification Board (BACB) and in good standing and must not exceed their certified scope of practice.

Note: Referrals (provider-to-provider or self-referred) can be done via phone, email, fax and hard copy mail. Providers must comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

Staff-to-member Ratio and Case Load Management

Staff-to-member ratios are established for safety and therapeutic efficacy. Ratios must be met and maintained at all times. Staff should be in direct contact and involved with the member during service delivery. Ratios must be maintained in accordance with the requirements of each individual service description array. ASD network providers must maintain the following staff-to-member ratios:

- LIPs must maintain a one-to-one staff-to-member ratio throughout treatment.
- ASD providers must maintain at least a one-to-one staff-to-member ratio throughout treatment, with the exception of group adaptive behavior treatment, in which case the RBT/BCBA/BCaBA must be directly engaged with the service and is not allowed to function in a background or support staff role. Additionally, ABA providers must adhere to the following caseload ratio guidelines, which presume the enrolled ABA provider is providing both professional RBT supervision as required by the BACB to the RBT assigned to the case, and separately, that the BCBA is delivering in-person, direct services to each member on their caseload. Additionally,

these guidelines represent the collective caseload per ABA provider, regardless of service location, company affiliation, or member's insurance:

- BCBA (doctoral and master's level) must maintain the following caseload ratio throughout treatment:
 - › Without the support of a BCaBA: Maximum 12 cases.
 - › With the support of a BCaBA: Maximum 16 cases.
- BCaBAs must maintain the following caseload ratio throughout treatment:
 - › Maximum 12 cases.
- Caseload counts are dependent on the amount of medically necessary therapy provided per member:
 - › 30–40 hours per week = one case
 - › 10–25 hours per week = $\frac{1}{2}$ case
 - › Less than 10 hours per week = $\frac{1}{4}$ case

LIPs, ABA and group providers are responsible for ensuring that all professionals rendering ASD services maintain current licensure and/or certification, as well as appropriate standards of conduct. While the group may receive Medicaid payments, the individual practitioner who rendered the service directly to a member or the supervising clinician is responsible for ensuring the quality and extent of services delivered.

Providers must have a policy for the definition of confidentiality issues, record security and maintenance, consent for treatment, a release of information, member's rights and responsibilities, retention procedures and code of ethics.

4

COVERED SERVICES AND DEFINITIONS

DEFINITIONS

1. **Covered Services** means a medical service, including those services coverable through the Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) program meeting the following criteria:
 - a. Is medically necessary.
 - b. Is provided to an eligible member by a participating provider.
 - c. Is the most appropriate supply or level of care consistent with professionally recognized standards of medical practice within the service area and applicable policies and procedures.
 - d. Is not rendered for convenience, cosmetic or experimental purposes.
2. **Provider** means an individual, firm, corporation, association or institution providing, or has been approved to provide, medical assistance to a member pursuant to the State Medical Assistance Plan and in accord with Title XIX of the Social Security Act, as amended.
3. **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)** is a program for persons under age 21 made pursuant to 42 U.S.C. Sections 1396a(a)(43), 1396d(a)(4)(B) and 1396d(r), and 42 C.F.R. Part 441, Subpart B to ascertain children's individual physical and mental illness and conditions discovered by screening services, whether such services are covered.
4. **Medically Reasonable and Necessary** means procedures, treatments, medications or supplies, (the provision of which may be limited by specific provisions, bulletins and other directives [42 CFR 440.230 (d) and SC Code of Regulations 126-300 (D)]), ordered by a physician, dentist, chiropractor, mental health care provider, or other approved, licensed health care practitioner to identify or treat an illness or injury which per [S.C. Code of Regulations 126-425(9)]:
 - a. Must be provided at appropriate facilities, at the appropriate levels of care and in the least costly setting required by the member's condition.
 - b. Must be administered in accordance with recognized and acceptable standards of medical and/or surgical discipline at the time the member receives the service.
 - c. Must comply with standards of care and not for the member's convenience, experimental or cosmetic purposes.
 - d. Medical necessity or any referral information must be documented in the member's health record and must include a detailed description of services rendered. The fact that a provider prescribed a service or supply does not deem it medically necessary.

COVERED SERVICES

All ASD services are subject to a medical necessity determination by SCDHHS through established utilization management policies based on the application of industry standards of medical practice, and through applications of reasonable limitations and criteria, as defined in section eight of this manual. Medically necessary ASD services are covered as follows:

State Plan Services

ASD Services

Pursuant to Social Security Act Section 1905(a)(13) and 42 C.F.R. § 440.130(c), these services are provided as preventive services and must be recommended by a physician or other licensed practitioner of the healing arts within his or her scope of practice under state law to prevent the progression of ASD, prolong life and promote the physical and mental health and efficiency of the individual.

Services to treat ASD, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD), are provided to Medicaid members under age twenty-one pursuant to the EPSDT benefit. Pursuant to Social Security Act Section 1905(a)(13) and 42 C.F.R. § 440.130(c), these services are provided as preventive services and must be recommended by a physician or other licensed practitioner of the healing arts within his or her scope of practice under state law to prevent the progression of ASD, prolong life, and promote the physical and mental health and efficiency of the individual. These services may be provided in the member's home, in a clinic setting, or other settings as authorized in the applicable section of the SCDHHS provider manual.

ASD treatment services include a variety of behavioral interventions which have been identified as evidence-based by nationally recognized research reviews or relevant and nationally recognized substantial scientific and clinical evidence, and/or any other intervention supported by credible scientific or clinical evidence, as appropriate to each individual. ASD assessment and treatment services must be medically necessary.

Service Location

These services may be provided in the member's home, a clinical setting, educational setting or other settings as authorized by SCDHHS.

Place of Service Code(s)	Place of Service Name	Place of Service Description
02	Telehealth Provided Other than in Patient's Home	The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.

03	School	A facility whose primary purpose is education.
10	Telehealth Provided in Patient's Home	The location where health services and health related services are provided or received, through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.

Telehealth

Telehealth Overview

CMS defines telehealth as the use of electronic information and telecommunications technologies to extend care when a provider and a patient are not in the same place at the same time.

Services rendered via telehealth may be rendered synchronously or asynchronously using a telecommunication system (audio/video) that permits interactive communications between a provider and a patient. The telecommunication system must be HIPAA compliant. SCDHHS only reimburses for services conducted synchronously with both audio and video components unless otherwise specified.

Services rendered via telehealth are not an addition to Medicaid-covered services but a mode of delivery of certain covered services. Quality of health care must be maintained regardless of the mode of delivery.

Telehealth Definitions:

Asynchronous telehealth, sometimes referred to as “store and forward” services, allows providers and patients to share clinical information without real-time, audio-video communication.

Asynchronous telehealth is only reimbursable when used for interprofessional consultations.

Synchronous telehealth is real-time, audio-video communication that connects physicians and patients in different locations.

Referring provider is the provider who has evaluated the member, determined the need for a consultation, and has arranged the services of the consulting provider for the purpose of consultation, diagnosis and/or treatment.

Consulting provider is the provider who evaluates the member via telehealth upon the recommendation of the referring provider.

Eligible Providers

Providers who meet the Medicaid credentialing requirements and are currently enrolled with the South Carolina Healthy Connections Medicaid program are eligible to bill for covered Medicaid services via telehealth in accordance with SCDHS coverage policies and the provider's scope of practice. Both the referring and the consulting providers must be enrolled in the Healthy Connections Medicaid program.

Referring Sites

A referring site (also called the patient site) is the location of an eligible Medicaid member at the time of the telehealth session. Medicaid member are eligible for services via telehealth only if they are presented from a referring site located in the SCMSA. Referring site presenters may be required to facilitate the delivery of this service. Referring site presenters must be a knowledgeable person on how the equipment works and able to provide clinical support if needed during a session.

Covered referring sites are:

- The office of a qualified practitioner defined as a physician, nurse practitioner (NP), certified nurse midwife (CNM), physician assistant (PA), LIP, BCBA-D, BCBA, BCaBA, RBT
- Hospital (inpatient and outpatient)
- Rural health clinics (RHCs)
- Federally qualified health centers (FQHCs)
- Community mental health centers
- Public schools
- Act 301 behavioral health centers
- Patient home

Consulting Sites

A consultant site (also called the distant site) is the site at which the provider is located at the time of the telehealth session. The provider performing the medical care must be enrolled in the South Carolina Medicaid program and provide services in accordance with the licensing and/or credentialing board and their scope of practice.

Practitioners at the distant site qualified to furnish services via telehealth are:

- Physicians
- NPs
- PAs
- LIPs (and associates)

- Physical, occupational and speech therapists
- ABA providers, to include BCBA-D, BCBA, BCaBA

Telehealth Covered Services

Specific services that are allowed to be delivered via Telehealth are documented in section eight of this manual.

Office and out-patient visits that are conducted via telehealth are counted towards the applicable benefit limits for these services.

Healthy Connections Medicaid allows the service to be delivered via telehealth when the service meets the following criteria:

- The member must be present and participating in the telehealth visit, unless otherwise specified in the procedure code description.
- The referring provider must provide pertinent medical information and/or records to the consulting provider via a secure transmission.
- Interactive audio and video telecommunication must be used, permitting encrypted communication between the distant site physician or practitioner and the Medicaid member. The telecommunication service must be secure and adequate to protect the confidentiality and integrity of the telehealth information transmitted.
- The telehealth equipment and transmission speed and image resolution must be technically sufficient to support the service billed. Any staff involved in the telehealth visit must be trained in the use of the telehealth equipment and competent in its operation.
- A trained healthcare professional at the referring site (patient site presenter) is required to present the member to the provider at the consulting site and remain available as clinically appropriate (this condition is waived when the referring site is the patient home).
- If the member is a minor (under 18 years old), a parent and/or guardian must present the minor for telehealth service unless otherwise exempted by State or Federal law. The parent and/or guardian need not attend the telehealth session unless attendance is therapeutically appropriate.
- The member retains the right to withdraw from the telehealth visit at any time.
- All telehealth activities must comply with the requirements of HIPAA: Standards for Privacy of individually identifiable health information and all other applicable State and Federal Laws and regulations.

- The member has access to all transmitted medical information, except for live interactive video, as there is often no stored data in such encounters.
- The provider at the distant site must obtain prior approval for service when services require prior approval, based on service type or diagnosis.
- The medical care is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the member's need.
- The medical care can be safely furnished.
- No equally effective, more conservative or less costly treatment is available Statewide.

NON-COVERED SERVICES

The following is a list of activities that are not Medicaid-reimbursable under the ASD policy for all ASD providers of both ABA services and non-ABA services.

- ASD services for any diagnoses other than ASD, or presumptive eligibility for ABA assessment within the medical care home
- Driving to and from ASD services appointments (i.e., member's house, clinic, or other locations). Mileage/time traveling is not to be billed to SCDHHS
- Any administrative tasks (i.e., filing, billing form completion, telephone, appointment scheduling, email), or supplies or items to include office supplies or therapeutic supplies (i.e., binders, building blocks, stickers, crayons, etc.)
- Asynchronous telehealth services
- Custodial, personal care and/or childcare
- Court appearances/testimony
- Supervision/staffing
- Any contact on behalf of a non-referred Medicaid member
- Consultation for member who are not involved in an ongoing assessment or treatment
- Consultation performed by persons supervised by an ASD network provider

- Any activities to attempt contact with members (e.g., attempted phone calls, home visits and face-to-face contacts, etc.)
- “Outreach” activities in which an agency or a provider attempts to contact potential Medicaid recipient
- Record audits or chart reviews
- Review of clinical record to become familiar with a member’s case
- Staff meetings, trainings and supervision
- Activities provided by anyone other than a person who meets the qualifications to render a service
- Completion of any specially requested information regarding members from the State office or from other agencies for administrative purposes
- Any social or recreational activities, or the supervision of such activities (e.g., playing basketball, watching movies, etc.); to include recess or break periods
- Documentation of service notes
- Unstructured member time (periods of inactivity, free, and unstructured time may be necessary for a member, but is not part of a billable service. This includes attempts to provide general supervision or bill for the presence of an RBT/BCaBA/BCBA/BCBA-D while children are on breaks or taking naps, or having meals)
- Educational services provided by the public school system such as homebound instruction, special education or defined educational courses (e.g., GED, adult development), or tutorial services in relation to a defined education course.
- Education interventions that do not include individual process interactions.
- Services provided to teach academic subjects or as a substitute for educational personnel (e.g., a teacher, teacher’s aide, an academic tutor, etc.).
- SCDHHS services in the school setting as a shadow, classroom aid, paraprofessional, or support personal to the member.
- General caregiver coaching and/or mentoring (e.g., life coaching, parent coaching, member mentoring)

- Services of an experimental, research, or unproven nature, or services in excess of those deemed medically necessary
- When prior authorization is required, dates of services not covered in the range of the Quality Improvement Organization (QIO) approval letter
- Services not identified on the individualized plan of care (IPOC; excluding those not required to be listed on the IPOC per policy)
- Services provided to children, spouse, parents or siblings of the member under treatment, or others in the member's life, to address problems not directly related to the member's issues and not listed on the member's IPOC
- Filing, mailing and faxing of any reports to other entities or individuals on behalf of the member
- Medicaid eligibility determinations and re-determinations
- Medicaid intake processing
- Completion of and monitoring of prior authorization requests for Medicaid services
- Required Medicaid utilization review
- Staff supervision of actual employment services
- Assisting member in obtaining job placements
- Assisting members in filling out applications (i.e., job, disability, etc.)
- Assisting members in performing the job or performing jobs for clients
- Waiting for and/or with a member in waiting rooms
- Any art, movement, dance or drama therapies
- Biofeedback
- Hypnotherapy
- Sensitivity training

- Encounter groups or workshops
- Canceled appointments or appointments not kept

Additionally, the following is a list of activities that are not Medicaid-reimbursable under the ABA service specific benefit:

- ABA services for symptoms and behaviors that are not part of the core symptoms of ASD (i.e., impulsivity due to Attention-Deficit/Hyperactivity Disorder (ADHD), reading difficulties due to learning disability, excessive worry due to anxiety disorder).
- ABA treatment that precludes, or requires the member's family to stop engaging with other critical supports for autistic members; to include but not limited to, speech therapy, occupational therapy, or IDEA recommended school-based curriculum and supports.
- BT/RBT/BCaBA training or supervision hours (direct or indirect) required for credentialing and/or BACB certification
- Time spent on documentation and/or report writing outside of what is included in current procedural terminology (CPT) code 97151.
- Planned ABA treatment interventions that involve aversive techniques or restraints.
- Services outside of the physical space of the home, clinic, office, school. Certain community settings such as sporting events, camps, and other settings are also excluded. Any location not listed explicitly must be reviewed and approved by the QIO.
- ABA services while the member is at another medical appointment to include another family member's appointment.
- ABA services provided by a clinic or agency owned by any private entity related to the same private entity that conducted the member's Autism Evaluation and Diagnosis.
- ABA services provided directly by the member's responsible adult (e.g., biological, adoptive, or foster parents, guardians, court-appointed managing conservators, other family members by birth or marriage). Billing for rendered ABA services by family members is considered a conflict of interest.
- Concurrent billing of 97153 with any other service or therapy is excluded except as detailed in Section 8.
- Any ABA service without routine delivery of 97156 during the prior authorization period.
- Reporting 97156 without routine delivery of 97153 and 97155
- Reporting 97153 without delivery of 97155 and 97156

- Reporting 97155 without delivery of 97153, during the same week. 97155 and 97153 are not required to be concurrently billed. Concurrent billing must meet specific threshold for direct delivery of both services.
- Two enrolled ABA providers billing at the same time under one CPT code.
- Non-ABA-services by ABA providers; including but not limited to cognitive behavior therapy, Dialectical Behavioral Therapy, Acceptance and Commitment Therapy, Prolonged Exposure, group psychotherapy, etc.
- ABA services designed to deliver educational curriculum, or assist member with homework or other educational assignments.
- Any childcare, personal care, respite, or other services provided as a substitute for the parent or other caregiver responsible for the member.

[ABA Services Billed by Private Individual and Group Enrolled Providers from School Place of Service Location](#)

ABA Services delivered in a school-based setting must be delivered by enrolled ABA individual and/or group providers and continue to meet medical necessity requirements. ABA services delivered in a school place of service location are only reimbursable when authorized as determined by the QIO in reviewing the initial IPOC for specific goals that are tied directly to a school-based setting and behavior excess or deficit. In order for ABA services to be authorized within a school-based service location, the member's updated Individualized Education Plan (IEP) and Functional Behavior Assessment and Behavioral Intervention Plan (or equivalent for non-public school placement) that was completed by the local educational entity, must be submitted during the prior authorization process and be incorporated into an appropriate IPOC that does not duplicate school-based educational autism supports.

The following activities are not Medicaid-reimbursable under the ABA service benefit when rendered in a school place of service location:

- ABA services without a current IEP, Functional Behavioral Assessment and Behavior Intervention Plan under the IDEA designation of autism spectrum disorder, as completed by the members' local public education facility.
- ABA services for a member that are written in a member's IEP and are required to be provided without charge by the local public education facility in accordance with the Individuals with Disabilities Act or other applicable laws and regulations. Current IEP/BIP ABA services will not be duplicated and are not reimbursable by Medicaid.
- ABA services that do not target a specific school-based goal and a specific behavior excess or deficit, as clearly indicated during prior authorization on the child's IPOC.

- Educational ABA services, such as services typically provided through a school curriculum.
- Educational/academic and vocational rehabilitation services. All educational/academic and vocational goals must be removed from the IPOC prior to giving approval.
- ABA services in the school setting designed to function as staff support, shadow, classroom aid, paraprofessional, or support person to the member.
- ABA services; wherein the enrolled provider is expected to deliver standardized school based curriculum or testing services.
- ABA services delivered by an uncredentialed BT. ABA services in the school setting may only be delivered by an RBT, BCaBA, BCBA, BCBA-D.

ABA Services Billed by Private Individual and Group Enrolled Providers from Home-Based Place of Service Location

ABA services delivered in a home-based setting must continue to meet medical necessity requirements. The following activities are not Medicaid-reimbursable:

- ABA services delivered in home settings when an adult caregiver is not physically present within the home.
- ABA services delivered in home settings, with the intent to deliver or facilitate independent educational or home-school curriculum.
- ABA services delivered in the home are not reimbursable when delivered by an uncredentialed BT. ABA services in the home setting must be delivered by a fully credentialed RBT, BCaBA, or BCBA who is targeting a specific behavior excess or deficit and is for a limited duration,

This list may not include all non-covered services. If you have questions regarding the types of services covered under this service array or otherwise covered by Medicaid, please contact the SCDHHS Medicaid Provider Service Center (PSC) at: (888) 289-0709. You may also submit an online inquiry at <https://www.scdhhs.gov/providers/contact-provider-representative>.

EPSDT Benefit

Children under the age of 21 are eligible for medically necessary services as part of the EPSDT benefit. Federal law at 42 U.S.C. §1396d(r), §1905(r) of the Social Security Act] requires state Medicaid programs to provide EPSDT for recipients under 21 years of age. The scope of EPSDT benefits under the federal law covers services that are medically necessary “to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening,” regardless of whether the service is covered under the State Plan. EPSDT benefit includes services provided at intervals that meet reasonable standards of medical practice and at intervals necessary to determine the existence of a suspected illness or condition. EPSDT benefit is detailed on the [SCDHHS EPSDT website](#).

5

UTILIZATION MANAGEMENT

For general policies regarding Program Integrity, Utilization Management, Fraud, Waste and Abuse providers must refer to the Provider Administrative and Billing Manual.

PRIOR AUTHORIZATION

Authorizations are a utilization tool that require participating providers to submit “documentation” associated with certain services for a member. Participating providers will not be paid if this “documentation” is not furnished to SCDHHS. Participating providers must hold the member and SCDHHS harmless as set forth in the Provider Participation Agreement if coverage is denied for failure to obtain authorization. SCDHHS contracts with a QIO for utilization review and prior authorization services. Providers must follow the prior authorization guidelines as outlined by SCDHHS before billing Medicaid. All ASD services must be determined medically necessary and have a prior authorization by the QIO.

Members with Medicare or any other payer are only required to obtain a prior authorization if Medicare or the primary carrier denied the service or the service is considered not covered. This is applicable only for services that require prior authorization by Medicaid.

ASD network providers must ensure that only authorized amounts of services are provided and submitted for reimbursement and that all services are provided in accordance with all SCDHHS policy requirements. Services are subject to frequency limitations as indicated in section eight of this manual. Services needed that exceed established frequency limitations must receive prior approval through the QIO. Providers are required to submit sufficient medical documentation to justify and support the need for services beyond the established limits. If SCDHHS or its designee determines that services were reimbursed when there was not a valid approval letter in the member’s file, the provider payments will be subject to recoupment.

To receive reimbursement from Medicaid, all prior authorization requests must be submitted to the QIO using one of the following methods:

- **Web Portal (preferred):** If using the web portal, the provider can download the approval document(s). The approval document(s) must be placed in the member’s clinical record prior to or at the time of the appointment for treatment.
- **Fax:** If the prior authorization requests are submitted via fax, the ASD Fax Cover Sheet must be included with the request along with supporting documentation such as SCDHHS forms and/or clinical documentation. The provider must check for primary health insurance using the Web Tool.

All applicable forms for requests for prior authorizations are posted to QIO website <https://scdhhs.acentra.com>.

QIO Customer Service Phone: (855) 326-5219
QIO Web Portal: <https://scdhhs.acentra.com/>
QIO Fax:: (855) 300-0082
Provider Issues Email: scproviderissues@acentra.com

For members enrolled in MCO, refer to the individual MCO plan regarding its services and authorization policies. Failure to comply with these requirements may result in denial or recoupment of payment.

Prior Authorization for LIP Providers

Once medical necessity has been established, the following services may be authorized to an enrolled LIP:

- Non-ABA ASD treatment services

The LIP must use the QIO system portal or fax to request prior authorization for the above services.

For initial treatment requests, the original comprehensive diagnostic assessment and/or required physician documentation of a prior ASD diagnosis and/or presumptive eligibility for ABA treatment services, as well as the individualized Plan of Care (IPOC) must be submitted to the QIO along with the SCDHHS ASD Prior Authorization Request Form.

For continued treatment, the most recent IPOC and progress summary spanning the previous authorized treatment period must be submitted to the QIO along with the SCDHHS ASD Prior Authorization Request Form. Continued treatment requests can be submitted up to 30 days prior and no later than 10 days prior to the expiration of authorized visits. Failure to obtain reauthorization prior to the provision of services may result in a denial of claims.

Prior Authorization for ABA Providers

Prior authorization requests for therapy services must be submitted by the ABA provider and must follow the guidelines outlined in the ASD services provider manual. SCDHHS's QIO will use InterQual's Applied Behavior Analysis Treatment Criteria to facilitate medical necessity determinations. All prior authorizations will be valid for a period of six months. Once medical necessity is determined and the Behavior Identification Assessment (BIA) and IPOC are completed, ABA providers may be authorized to deliver the services as outlined in section eight.

Initial ABA Treatment Requests

For initial treatment requests, the following documentation must be submitted to the QIO along with the SCDHHS ASD Prior Authorization Request Form:

- Confirmatory documentation that the member meets Medical Necessity Criteria as outlined in section eight for ASD services; as represented by:
 - The comprehensive diagnostic assessment, or
 - Required physician documentation of a Medical Care Home based assessment, or
 - Required physician documentation of presumptive eligibility for ABA treatment services
 - Member's BIA
 - A functional behavioral assessment (FBA) is required as outlined in section eight when addressing any maladaptive behavior, when requesting more than 15 hours of 97153, or when requesting services delivered in a school-based service location.
 - Copies of current treatment plans from all providers on the members' rehabilitative therapy team, to include ST/OT and PT.

- Member's IPOC:
 - The IPOC must clearly indicate individualized goals, and delineate those goals by specific service location.
 - The IPOC must clearly indicate individualized goals, and delineate those goals by ABA Treatment service code
 - The IPOC can not include recreational, educational, academic, or vocational goals.
 - The IPOC can not include goals that indicate the ABA provider would be acting in the capacity of a shadow, classroom aid, paraprofessional, personal care attendant, childcare worker, or the member's support person.
 - The IPOC must include clear transition and fade criteria.
 - IPOC behavioral goals can not be duplicative as a means to obtain additional service units.
 - The IPOC can not aim to treat problematic behaviors that are the clear result of unaddressed or ongoing or unstable medical issues; such as constipation, eczema, allergies, illness, recent surgical procedure, etc.

- If ABA services are requested to be delivered in a school place of service, submission of both of the following are required to ensure the utilization management team can make an appropriate determination:
 - The member's current IEP with an IDEA designation of ASD, and
 - The member's current FBA and BIP

If service authorizations do not meet the needs of the member, reconsideration of services will be required. In such scenarios, the most recent IPOC with modified goals or needs as well as supporting clinical documentation must be submitted to the QIO, supporting clinical documentation can include but is not limited to:

- Barriers to progress.
- Issues of member health and safety.
- Sophistication or complexity of treatment protocols.
- Family dynamics or community environment changes.
- Lack of progress.

- Changes in treatment protocols.
- Transitions with implications for continuity of care.

Continuation of ABA Treatment Requests

The continued medical necessity of ABA therapy treatment services must be demonstrated by a thorough explanation of the following:

- The members' progress towards all of the following:
 - Minimizing or eliminating targeted problem behavior(s); and
 - Reducing targeted area(s) of functional deficit or delay (as demonstrated by assessment instrument scores over time); or
 - Acquiring new communication, social, self-help, or other adaptive behavioral skills in the targeted area(s) of deficit.
- Reaching the transition and fade criteria outlined in the initial request.
- If the member has failed to demonstrate progress in the above areas, medical necessity for continuation of ABA services can be addressed through a description of the list of variables that impacted the member's response to their ABA therapy treatment services and a detailed description of how those variables prevented the member's anticipated progress towards their IPOC goals and objectives since the member's immediately preceding authorization period.
- If an estimated goal or objective mastery date or timeframe is extended, a narrative must be included that identifies the mastery date/timeframe was extended to, identifies the barrier(s) to mastery that required the extension, and describes the modifications to practices, procedures, and strategies that were made to address the lack of progress. Please ensure all IPOC continued/in progress goals meet these criteria.

In addition to the narrative summary, the most recent IPOC and progress summary spanning the previous authorized treatment period must be submitted to the QIO along with the SCDHHS ASD Prior Authorization Request Form, as well as updated direct observations, updated educational and behavioral assessments as completed by the member's school, and all updated treatment plans from the member's ST/OT/PT.

Continued treatment requests can be submitted up to 30 days prior and no later than 10 days prior to the expiration of authorized visits. Failure to obtain reauthorization prior to the provision of services may result in a denial of claims.

IPOC Annual ABA Treatment Review

Documentation for an annual treatment reviews must include the submission of all of the following to the QIO along with the ABA prior authorization Request Form:

- A thorough explanation of the members' progress towards all of the following:

- Minimizing or eliminating targeted problem behavior(s); and
 - Reducing targeted area(s) of functional deficit or delay (as demonstrated by assessment instrument scores over time); or
 - Acquiring new communication, social, self-help, or other adaptive behavioral skills in the targeted area(s) of deficit
 - If the member has failed to demonstrate progress in the above areas, medical necessity for continuation of ABA services can be addressed through a description of the list of variables that impacted the member's response to their ABA therapy treatment services and a detailed description of how those variables prevented the member's anticipated progress towards their IPOC goals and objectives since the member's immediately preceding authorization period.
 - Progress towards member's transition and fade criteria
- All progress summaries
 - Member's updated BIA
 - Member's updated FBA as outlined in Section 8 when addressing any maladaptive behavior, when requesting more than 15 hours of 97153, or when requesting services delivered in a school-based setting
 - Updated treatment plans from all providers on the members' rehabilitative therapy team, to include ST/OT and PT.
 - Updated IPOC:
 - The IPOC must clearly indicate individualized and developmentally appropriate goals, and delineate those goals by specific service location.
 - The IPOC must clearly indicate individualized individualized and developmentally appropriate goals, and delineate those goals by ABA Treatment service code
 - The IPOC can not include recreational, educational, academic, or vocational goals.
 - The IPOC can not include goals that indicate the ABA provider would be acting in the capacity of a shadow, classroom aid, paraprofessional, personal care attendant, childcare worker, or the member's support person.
 - If ABA services are requested in school place of service, submission of both of the following are required to ensure the utilization management team can make an appropriate determination:
 - The member's updated IEP with an IDEA designation of ASD, and
 - The member's updated FBA and BIP

Annual treatment requests can be submitted up to 30 days prior and no later than 10 days prior to the expiration of authorized visits. Failure to obtain reauthorization prior to the provision of services may result in a denial of claims.

Approval Letter

Approvals for ASD services will include:

- The member's Medicaid number

- The ASD network provider name
- The ASD network provider NPI number
- The prior authorization number
- The authorization (beginning) date and the expiration (ending) date, which establishes the treatment period
- The specific service(s) authorized to be provided
- The maximum authorized amount (number of units)

DRAFT

6

REPORTING/DOCUMENTATION

General policies for Medicaid members' health records requirements and documentation are detailed in the Provider Administrative and Billing Manual. In addition to the general policies, autism spectrum disorder providers must comply with specific policies for health records requirements and documentation detailed below.

HEALTH RECORDS

In addition to providers' compliance with state and federal laws and regulations regarding health record retention requirements [e.g., Social Security Act 1902(a)(27), 42 CFR 431.107]. SCDHHS requires ASD providers to retain on site, all health and fiscal records pertaining to Medicaid members for a minimum period of four years after the last payment was made for services rendered, to facilitate audits and reviews of the member's health record. No other documentation (except for hospital records) will be accepted in lieu of a treatment record. This includes prior authorization forms, ledger cards, claim forms, and computer records.

Health Record Compliance requirements

Providers must:

- Document the rationale and justification of medical necessity for services, including all findings, diagnosis and supporting information.
- Detail the extent of the service performed to ensure the service is billed with the correct and appropriate level of the procedure code, as defined in the CPT or the Healthcare Common Procedure Coding System (HCPCS) nomenclatures and descriptors, or as indicated in the SCDHHS policy.
- Ensure that health records are signed and dated at the time of service or signed by the rendering provider including the date and time, as appropriate to the media, prior to the filing of the claim for reimbursement. Information including the rendering provider, supervising provider (if applicable), service performed, and date and time of the service must be verifiable. By signing the record, the signor attests to the completeness and accuracy of the information they provided.

Medicaid services that are not properly documented in clinical notes are subject to denial or recoupment. All required documentation must be prescient in the health record before the provider files claims for reimbursement. All services performed must be recorded in the member's health record, which must be available as required by the Participating Provider Agreement.

Medical Service Documentation

Healthy Connections providers are required to maintain comprehensive treatment records for each patient that meet professional standards for risk management and includes sufficient documentation of services rendered to justify Medicaid participation. All clinical documentation must be signed by either the enrolled BCBA, BCaBA, or LIP as applicable. At minimum, adequate documentation reflects:

- Services performed
- Justification of medical necessity for ASD services
- Performing provider and supervising provider (when required)
- Date and time period the services were performed
- Referral form
- A BIA for ABA services.
- Signed, titled and dated IPOC.
- Signed releases, consents, Member Rights acknowledgment, and confidentiality assurances for treatment.
- Signed, titled and dated clinical service note (CSN) and progress summaries, all of which must be signed by the enrolled BCBA, BCaBA, or LIP as applicable.
- Copies of all written reports, and any other documents relevant to the care and treatment of the member.

Additional Program Requirements

ABA providers must adhere to additional program requirements. Additional program requirements for ABA network providers include:

- Services must be provided in accordance with ABA practice guidelines.
- One provider may provide multiple levels of service to the same member, but not simultaneously.
- RBT and BCaBA supervision must be provided in accordance with BACB guidelines
- Following BACB guidelines, each RBT must be supervised for a minimum of 5% of the hours spent providing ABA services per month. Supervision must include at least two face-to-face, real-time contacts per month, during at least one of which the supervisor observes the RBT providing direct services to the member. Professional supervision is not reimbursable by SCDHHS or reportable under ABA codes as described in Section 8. BACB required professional supervision should not be confused with direct services.
- Following BACB guidelines, case supervision must be provided by a BCBA-D, BCBA or BCaBA.

- BCaBAs must be under the supervision of a BCBA-D or BCBA.
- The BCaBA who acts as the primary behavior analyst is responsible for disclosing via a consent form to the member:
 - An acknowledgment that they are being supervised by a BCBA-D or BCBA.
 - Name and contact information for the supervising BCBA-D or BCBA.
- Technicians will be granted a 90-day grace period to acquire an RBT credential, beginning from the date of their first hire. The 90-day period does not reset if the BT's employment status changes, or if the BT does not obtain their RBT credential. During this 90 day period, the BT may only deliver ABA treatment in a clinic based setting when a BCBA or BCaBA is directly on site. Uncredentialed BTs can not deliver ABA treatment services in school or home based settings. It is the enrolled providers responsibility to ensure the BT does not render ABA services outside of the one-time 90 day grace period.
- The behavior analyst (BCBA or BCaBA) will be responsible for continuity of care regarding members who are under the care of technicians who do not obtain an RBT credential within 90 days.

Consent for Treatment

A consent form dated and signed by the member (age 16+), parent, legal guardian, primary caregiver or legal representative must be obtained at the onset of treatment and documented in the member's clinical records. If the member is accompanied by next of kin or a responsible party, and the member is unable to sign the consent form due to marked functional impairments, the next of kin or responsible party must sign the consent form. A new consent form must be signed and dated with every new prior authorization, whenever a service is added, and/or each time a member is readmitted to services after discharge.

Referral Process

Enrollment in the Medicaid program does not provide a guarantee of referrals or a certain funding level. Failure to comply with all Medicaid policy requirements may result in sanctions up to termination of Medicaid enrollment.

Referrals to ASD network providers will be recognized when:

- A physician or licensed practitioner of the healing arts (LPHA) refers an eligible member to an ASD network LIP or physician for a comprehensive diagnostic assessment to establish an ASD diagnosis and identify medical necessity.
- An eligible Medicaid member self-refers to an ASD network LIP or physician for a comprehensive diagnostic assessment to establish an ASD diagnosis and medical necessity.

- A physician or LPHA refers an eligible member with a prior-established ASD diagnosis that meets medical necessity requirements to an ASD network LIP or ABA provider for ASD treatment services.
- An eligible Medicaid member with a prior-established ASD diagnosis that meets medical necessity requirements self-refers to an ASD-network ABA or LIP for ASD treatment services.
- An eligible Medicaid member with presumptive eligibility for ASD services as outlined in Section 8, is referred by a physician to an ASD network ABA or LIP for ASD treatment and services.

Note: Referrals (provider-to-provider or self-referred) can be done via phone, email, fax and hard copy mail. Providers must comply with the provisions of HIPAA, Public Law 104-191.

Transition, Discharge and Continuity of Care

The authorizing entity is responsible for determining the duration of treatment based on the individual needs of the member.

Transition and discharge planning must begin with the initiation of services and include a written plan containing specific details of monitoring and follow-up. Parents, caregivers and other involved professionals should be consulted three to six months prior to the first change in service. A description of roles and responsibilities of all providers, and effective dates for behavioral targets that must be achieved prior to the next phase, should be specified and coordinated with all providers, the member and family members. Transition and discharge planning from all treatment programs should involve a gradual step down in services over six months or longer.

Members should be considered for discharge from treatment when they meet the following criteria:

- Level of functioning has significantly improved relative to standardized measures of behavior and ability.
- Member requests discharge (and is not imminently dangerous to self or others).
- Member requires a higher level of care (i.e., inpatient hospitalization or Psychiatric Residential Treatment Facility).
- Member reaches age 21.

Coordination of Care

SCDHHS expects coordination of care and continued communication between the referring physician, state agency, the ASD network provider, and any auxiliary or rehabilitative therapy service providers. There should be evidence in the record of clinically appropriate coordination between the ASD network provider, the referring entity regarding treatment, and the member's school, if applicable. The ASD network provider may provide the referring entity with clinical service documentation describing the services rendered, outcomes achieved, and any recommendation for continued or additional services. These reports are not separately reimbursable but considered part of the member's overall care.

Emergency Safety Intervention (ESI)

The ESI policy applies to any community-based provider(s) that has policies prohibiting the use of seclusion and restraint but who may have an emergency situation requiring staff intervention.

Providers must have a written policy and procedure for emergency situations and must ensure that the practitioners are trained and prepared in the event of an emergency situation.

If the provider intends to use restraint and/or seclusion, the provider is responsible for adhering to the following requirements:

- Providers must ensure that all staff involved in the direct care of a member successfully complete a training program from a certified trainer in the use of restraints and/or seclusion prior to ordering or participating in any form of restraint.
- Training should be aimed at minimizing the use of such measures, as well as ensuring member safety.
- Providers must use standardized ESIs.
- Providers must have a comprehensive written policy that governs the circumstances in which restraint and/or seclusion are being used that adhere to all State licensing laws and regulations (including all reporting requirements).

If utilizing seclusion and/or restraint, failure to have these policies and staff training in place at the time of rendering services will result in termination from the Medicaid program and possible recoupment of payments.

Clinical Service Notes (CSN)

Each discrete service should have its own CSN capturing service and bill time. ABA providers must document in accordance with ABA standards and guidelines. Documentation in the CSN must justify the level of service performed and billed to Medicaid.

At minimum, each CSN must include:

- The member's name and Medicaid or organizational ID.
- Date of service.
- Name of the service provided.
- Place of service.
- Duration of service (start and end time for each service delivered).
- Narrative justification of medical necessity for the service.
- Treatment performed (the nature of the member's treatment, any changes in treatment, discharge, crisis interventions).
- Observation (any changes in medical, behavioral or psychiatric status).
- Treatment planned.
- Signatures by both the enrolled BCBA, BCaBA, or LIP as applicable, as well as the BT/RBT rendering the service.

In addition, the documentation for individual and family treatment must address the following items in order to provide a pertinent clinical description, ensure that the service conforms to the service description, and to authenticate the charges:

- The specific objective(s)/ goal(s) from the IPOC toward which the session is focused.
- The structured activities of the member in the session.
- The member's response to the intervention/treatment.
- The specific intervention(s) used.
- The member's progress or lack of progress made in treatment.
- Recommendation and future plans for working with the member.
- If 97155 is documented and reported, the clinical service note must include a detailed narrative description of the BCBA's member-directed involvement and resultant protocol modifications or an explanation for the steps taken to target the protocol, and why the service did not result in a modification to the members' protocol.

Note: All documentation must support the number of units billed.

Individualized Plan of Care (IPOC)

The IPOC is a comprehensive plan of care outlining the service delivery that will address the specific strengths and needs of the member. The IPOC must be individualized and specify problems to be addressed, goals to be worked toward and the strengths of the member. The IPOC must address any behavioral challenges reported by the caregiver. Goals should include the generalization of skills to member's home and communication environment. The IPOC must be developed prior to the delivery of a service with the full participation of the member and his or her family and/or caregivers. Prior authorization for treatment services can be provided only after an IPOC has been completed. The IPOC will be person/family centered and the member must be given the opportunity to determine the direction of his or her treatment, as appropriate. When the member can not determine the direction of their treatment; the caregiver's requests to support behavioral goals must be prioritized.

The IPOC must contain the signature and title of the enrolled ASD network provider and the date signed. The member and/or the legal guardian(s) must sign the IPOC indicating they have been involved in the planning process, that their concerns regarding challenging behaviors have been addressed in the IPOC, and that they have been offered a copy of the IPOC.

If the member refuses or is unable to sign the IPOC, the clinician must document this. If it is considered clinically inappropriate for the member to sign the IPOC, clinical justification must be documented on the IPOC. When the member is unable to sign the IPOC, the IPOC must be signed by the member's caregiver or legal guardian. Services will not be approved for requests that contain unsigned IPOCs.

For all members, the IPOC must be completed in its entirety to address the following:

- The member's strengths, needs, abilities and preferences.
- The goals and objectives of treatment, which must be developmentally appropriate and relate to issues identified in the child's behavioral identification assessment.
- An outline to address the assessed needs of the member, including, but not limited to, specific description of the recommended amount, type, frequency, setting, and duration of ASD treatment services needed to best meet the needs of the member.
- Specific treatment activities or interventions that target differentiated goals, per planned service delivery location.
- Amount and type of parent/caregiver participation, as applicable to the member.
- Parent/caregiver participation is required, and is designated through specific parent/caregiver goals that must be addressed during the delivery of family adaptive behavior treatment guidance (97156), and follow an evidence-based parent treatment curriculum. Generalized caregiver coaching services are not reimbursable; however safety care training for families in a 1:1 setting are authorized when tied to IPOC goals related to address severe maladaptive behaviors.
- The date of each completed progress summary and annual re-development.
- Signature, title and date by the multidisciplinary team members including the parent and/or caregiver.

The IPOC must be completed no later than the 10th business day after an initial assessment meeting with a LIP or a behavior assessment with an ABA provider is completed. If the IPOC is not completed within this time frame, services rendered are not Medicaid reimbursable.

The IPOC must be reviewed as a part of the regular progress summary. These progress summaries must be completed quarterly (i.e., every 90 days) for ASD services. If the provider determines during the course of treatment that additional services are required, the services must be added to the treatment plan. The original IPOC signature date stands as the date to be used for all subsequent reviews and reformulations.

A new IPOC must be developed every 12 months. If services are discontinued, the ASD service provider must indicate the reason for discontinuing treatment on the POC. The caregiver must sign the IPOC any time it is reformulated.

Services added or frequencies of services changed in an existing IPOC must be entered on the hard copy document, for paper records; the member's signature is required each time there is a change updated or appended to the POC.

ASD Therapy Progress Summary Report

A progress summary spanning the previous authorized treatment period must be completed for all members. The progress summary must include:

- The specific objective(s) from the IPOC that were a focus of treatment.
- Specific treatment activities or interventions.
- The goals that have been met.
- Cumulative graphs of goals and objectives demonstrating progress or areas of concern (ABA providers only), including baseline data.
- Explanation of any delayed progress, to include any barriers to progress, toward IPOC goals.
- Explanation of any failure to provide the recommended services and their frequency.
- Amount and type of parent/caregiver participation, as applicable to the member.
- Summary of the treatment plan for the upcoming treatment period, to tie into objectives and goals of the POC, as well as a caregiver coordination summary.
- Signature, title and date by the multidisciplinary team members including the parent and/or caregiver.

The progress summary must be completed no sooner than 30 days prior to the expiration of the current authorization period and no later than the 10th day of the month immediately following the last date of authorized treatment. Progress summaries must cover any dates of service not previously reported on in a prior progress summary.

Note: The due date for the progress summary report is based on the last date of the authorized treatment or final date of service.

7

BILLING GUIDANCE

General Billing Guidance, such as Usual and Customary Rates; Timely Filing; Third Party Liability and Coordination of Benefits (COB); Adjustments and Refunds; Remittance Advices; and Electronic Fund Transfer, is detailed in the Provider Administrative and Billing Manual. Additional Billing Guidance specific to ASD services is detailed in this manual.

Providers must follow the National Correct Coding Initiative (NCCI) edits and its related coding policy, unless otherwise indicated in this manual. For detailed information about the NCCI refer to the Administrative and Billing Provider manual. Providers must bill for ASD services utilizing the procedure codes from the current editions of HCPCS and the CPT. Procedure codes that deviate in description from the HCPCS/CPT assigned description, will be indicated in section 8 of this manual.

For additional information on procedural coding, refer to the Provider Administrative and Billing Manual.

Same-day Service Guidelines

When a child is receiving multiple services on the same day, the state or an entity designated by the State to perform prior authorization and/or quality/utilization reviews, may review a child's IPOC to ensure the number of services rendered in totality do not exceed a reasonable limit that would interfere with child's other activities of daily living (i.e., school, recreation, and/or sleep). If a child is receiving multiple services within the same day, the services must be rendered during different time frames.

Service Unit Contact Time

SCDHHS has adopted the Medicare Eight-Minute Rule for ASD services. This means a provider may not bill for a unit of service if the service is provided for less than eight minutes and it is the only ASD service provided to the member that day. If any ASD service is performed for seven minutes or less on the same day as another ASD service with the same procedure code that was also performed for seven minutes or less to the same member, then the provider may bill for the appropriate number of units using the table below. The expectation is that a provider's direct member contact time for each unit will average at least 15 minutes in length. If a provider has a consistent practice of billing less than 15 minutes for a unit, these situations will be highlighted for review.

Units	Number of Minutes
1 unit	≥ 8 minutes through 22 minutes
2 units	≥ 23 minutes through 37 minutes
3 units	≥ 38 minutes through 52 minutes
4 units	≥ 53 minutes through 67 minutes
5 units	≥ 68 minutes through 82 minutes
6 units	≥ 83 minutes through 97 minutes
7 units	≥ 98 minutes through 112 minutes
8 units	≥ 113 minutes through 127 minutes

The pattern remains the same for treatment times in excess of 2 hours.

DRAFT

8

BENEFIT CRITERIA AND LIMITATION

The criteria outlined in SCDHHS' ASD Manual are based around procedure codes as defined in the HCPCS or CPT Code set (unless otherwise in this manual). Healthy Connections providers are required to maintain comprehensive treatment records that meet professional standards for risk management. Please refer Section 6 for additional details.

The **Healthy Connections** Covered ASD services are defined as follows:

1. State Plan Covered Services
2. EPSDT Services (Non-State Plan Covered Services)

This manual will provide the criteria, documentation required, and benefit limitations for each covered service.

State Plan Covered ASD Services

ABA Therapy Services

ABA Assessment Services for IPOC Development

Assessments are to be completed in-person by a BCBA-d, BCBA, or BCaBA. Assessments must include direct observation in the member's natural environment and measurement of member's behavior in structured and unstructured situations, determination of baseline levels of adaptive and maladaptive behaviors and functional behavior analysis as appropriate. Assessment services can only be offered and completed when the ABA provider is able to ensure they can also provide the ABA treatment services deemed medically necessary by the BIA, FBA and IPOC. The following service descriptions are based on the CPT coding guidelines.

Behavior Identification Assessment (BIA; 97151)

Administered in-person with the member and caregiver. Must be completed by a BCBA-D, BCBA or BCaBA. 97151 does not require prior authorization, but claims are subject to postpayment review if member is promised access to ABA services by a provider or group that does not have the capacity to provide medically necessary services as indicated by the resulting BIA. The BIA can not be completed by telehealth. Reporting for 97151 includes administration of direct and/or indirect measures, standardized and non-standardized tests, detailed behavioral history, patient observation in the child's natural environment and all settings where ABA treatment is requested, caregiver interview that actively asks above, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s) and preparation of a report.

If ABA services are planned for school place of service, the BIA must include a school-based observation that highlights the medical necessity of services delivered in the school setting, as well as a detailed functional behavior assessment.

All BIA services must include all of the following assessments, with the dates that each assessment was administered. Assessments must be updated with every request of initial or continuing ABA services:

- Clinical Interview with caregiver seeking ABA Treatment; and
- Direct patient observation in patient’s natural environment and in all settings where ABA treatment is being requested (Home and/or Clinic); and
- Vineland Adaptive Behavior Scales (Vineland) Interview - All domains, including the maladaptive behavior domain; and
- Behavioral Health Index (BHI); and
- Questions about Behavioral Function (QABF) OR the Functional Assessment Screening Tool (FAST) administered with caregiver seeking ABA treatment; and,
- At least one of the following skills or functional assessments:
 - Promoting the Emergence of Advanced Knowledge (PEAK)
 - Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP) – MUST include the Barriers Assessment AND the Transitions Assessment
 - Assessment of Basic Language and Learning Skills- Revised (ABLLS-R)
 - Social Responsiveness Scale (SRS)
 - Assessment of Functional Living Skills (AFLS)
 - Essentials for Living (EFL)
 - Early Start Denver Model
 - PEAK Autism Symptoms and Behavioral Observation Summary (PAS-BOS)
- A functional behavioral assessment (FBA) is **also** required as part of the BIA to support prior authorization requests for any of the following:
 - Treatment for >15 hours per week of 97153, OR
 - Treatment for any goals related to maladaptive or challenging behaviors, OR
 - Treatment for any goals planned to be delivered in a school-based service location
 - If any of the above three criteria are met, an FBA must be included with prior authorization for initial AND continuation of service requests and include ALL of the following additional measures:
 - › Interview-Informed Synthesized Contingency Analysis (IISCA) or Functional Analysis Interview (FAI); and
 - › Direct Observation of child in EVERY service location where ABA Treatment is being requested (School, Clinic, and/or Home) with ABC Data, Scatterplot Recording, Event Recording, and Standard Celeration Chart (SCC); and

- › Clearly identified functions of observed behaviors. FBAs and BIAs that include plans to update an FBA or IPOC after authorization to later include data or clarify functions of behavior that were not observed during the authorization period, will not be approved.
- › Crisis plan

Behavior Identification Supporting Assessment – One Technician (97152)

Administered by a RBT under the direction of a physician or other qualified provider, this face-to-face service requires prior authorization and is intended to gather information that supports the identification of maladaptive or problematic behaviors noted in the initial assessment conducted by the BCBA or BCaBA.

97152 can not be delivered concurrently with any ABA treatment services and is not intended to replace the expected data collection and documentation that results during RBT delivery of 97153. This assessment service may be provided at multiple points in ABA services, to include the following:

- After the BCBA/BCaBA's initial assessment;
- During periods of transition between two settings, such as during an activity at school as well as an activity in the home, in order to determine ways behaviors manifest in various settings

Behavior Identification Supporting Assessment – Two or More Technicians (0362T)

To meet criteria for this assessment, the following components must be met:

- Administered by the physician, BCBA, or BCaBA who is on site*;
- With the assistance of two or more technicians;
- A member who exhibits destructive or aggressive behavior; and
- The service must be conducted in an environment that is customized to the member's behavior.

Note: "On site" is defined as being physically "immediately available and interruptible," allowing the physician, BCBA, or BCaBA to join the session if needed.

This service is not intended to be used in a crisis situation, such as if behavior occurs unexpectedly, and multiple technicians are needed for safety, but shall be a planned assessment when the goal is to thoroughly assess maladaptive behaviors that are reported or observable during the initial phase of the assessment.

Note: In determining total service units for billing purposes, the duration of the service is the total amount of time all technicians/providers were present with the member in the session. Service units are not multiplied by number of technicians/providers present in the session. Billing is completed by the qualified primary provider (i.e., physician, BCBA, BCaBA).

Service Documentation

An interpretation of the results must be documented in the IPOC as well as an explanation of how the results translate into the requested hours that are recommended for treatment. Providers may include additional assessments, data, and information deemed clinically appropriate.

Staff-to-Member Ratio

Unless the service specifies more than one technician, the BIA and Behavior Identification Supporting Assessment must be completed one-on-one with the member, with the addition of collaterals as necessary.

ABA Treatment Services

Treatment services for ABA are provided via authorization once an IPOC is submitted and approved. ABA services are furnished by a BCBA-D, BCBA, BCaBA, RBT or a BT in accordance with their competency parameters, as per the BACB. BCaBAs, RBTs, and BTs furnishing services must be under the direct supervision of a BCBA within their scope of competency.

Prior authorization requests must indicate that members will be receiving direct ABA treatment via 97153, 97155, AND 97156 at a minimum. Direct treatment service requests will not be authorized:

- For any ABA codes without routine and consistent delivery of 97156.
- For 97156 without routine delivery of 97153 and 97155
- For 97153 without delivery of 97155
- For 97155 without delivery of 97153
- For 97153 in a school setting, without school-based goals specifically identified in the members' IPOC
- For 97154 without specific individualized goals that will be addressed in a group setting, and are clearly indicated on the IPOC.

Authorized synchronous audio/visual telehealth services are available for established patients only where indicated below. Services provided via telehealth are to be reimbursed in lieu of, not in addition to, those provided face-to-face. Use of a GT modifier will be required for any telehealth visits in addition to any other modifier(s) required for the service. The GT modifier will be listed in the secondary modifier position, with any other required modifier listed in the primary modifier position.

The following service descriptions are based on the CPT coding guidelines.

Direct Treatment

Adaptive Behavior Treatment by Protocol (97153)

Administered by a BCBA-D, BCBA, BCaBA, or a technician face-to-face with one member under the direction of a BCBA-D, BCBA or BCaBA, utilizing a behavioral intervention protocol designed in advance by the enrolled BCBA-D, BCBA or BCaBA responsible for the duration of the member's treatment during the prior authorization period.

Treatment protocols must be designed to clearly address specific individualized goals from the IPOC and be tailored to a specific setting. A functional behavior assessment is required and maladaptive/problematic behaviors must be prioritized if treatment is planned for greater than 15 hours per week of 97153, or if any maladaptive behaviors are addressed, or if treatment by 97153 is planned to be delivered in a school service location.

97153 approved for delivery in school or home service locations can not be rendered by an uncredentialed BT. BTs operating under the 90 day grace period can only render services in a clinic setting, when a BCBA or BCBA-D is on site to provide requisite supervision. 97153 rendered in home and school service locations must be delivered by a BCaBA/BCBA/BCBA-D.

Group Adaptive Behavior Treatment by Protocol, multiple patients, performed by an RBT (97154)

Administered by an RBT under the direction of a qualified healthcare professional, with two to six members, utilizing a behavioral intervention protocol designed in advance by the BCBA-D, BCBA or BCaBA. Treatment protocols must be designed to clearly address specific Individualized goals from the IPOC, that can only be addressed during group treatment. This service can not be used to bill for general supervision of group or play activities to include; nap, recess, or outdoor play; unless the RBT is specifically engaged with a targeted treatment goal.

Adaptive Behavior Treatment with Protocol Modification (97155)

Administered directly by a BCBA or BCaBA face-to-face, in the room, with a single member. The BCBA or BCaBA resolves one or more problems with the protocol and may simultaneously instruct a technician and/or guardian(s)/caregiver(s) in administering the modified protocol. Protocol Modification can be rendered at the rate of 10% of weekly render 97153 treatment hours. 97155 can only be billed for the time that the enrolled provider spends in session, with the member. The percentage of rendered and billed 97155 units can not exceed 10% of the 97153 units that were rendered to the patient, regardless of the amount on units approved through prior authorization.

97155 is intended to be delivered in person, directly to the patient. This code will not be reimbursed through telehealth on a routine basis. Up to 25% of the authorized and rendered 97155 units may be approved for use with a GT modifier on a case by case basis; provided that the GT modifier is requested during the prior authorization process for a member who will only be receiving in-home ABA services in a rural location with limited access to ABA treatment.

Post-payment review must indicate an “In-Person to Telehealth delivery ratio” of no more than 3:1. Post-payment review will also be conducted to verify that 97155 service units have not been used to document professional BACB supervision requirements, asynchronous telehealth services, or direct case supervision that does not explicitly meet the requirements for adaptive behavior with protocol modification.

Clinical service notes should include a detailed narrative indicating one of the following:

- The BCBA-D, BCBA, or BCaBA conducts 1:1 direct treatment with the patient to observe changes in behavior or troubleshoot treatment protocols; or
- The BCBA-D, BCBA, or BCaBA joins the patient and the technician during a treatment session to direct the technician in implementing a new or modified treatment protocol.

Adaptive Behavior Treatment with Protocol Modification –Two or More Technicians (0373T)

This face-to-face treatment service for protocol modification requires the following components:

- Attestation that service is administered by the physician, BCBA, or BCaBA, who is on site*;
- With the assistance of two or more technicians;
- A member who exhibits destructive or aggressive behavior; and
- The service must be conducted in an environment that is customized to the member's behavior.

Note: “On site” is defined as being “immediately available and interruptible,” allowing the physician, BCBA, or BCaBA to join the session if needed.

This service is not intended to be used in a crisis situation, such as if behavior occurs unexpectedly, and multiple technicians are needed for safety, but shall be a planned intervention.

Note: In determining total service units for billing purposes, the duration of the service is the total amount of time all technicians/providers were present with the member in the session. Service units are not multiplied by number of technicians/providers present in the session. Billing is completed by the qualified primary provider (i.e., physician, BCBA-D, BCBA, BCaBA). This service may not be billed concurrently with Adaptive Behavior Treatment with Protocol Modification.

Family Adaptive Behavior Treatment Guidance (97156)

Administered by a BCBA or BCaBA with the member's legal guardian(s), without the presence of a member, and involves identifying behaviors and deficits and teaching guardian(s)/caregiver(s) of one member to utilize treatment protocols designed to reduce maladaptive behaviors and/or skill deficits. At least one hour of Family Adaptive Behavior Treatment Guidance is required to be rendered during each month of authorized and rendered 97153 services, to support the transferability of skills between settings, and to validate the continuation of ABA services. This treatment must be clearly indicated through specific parent/caregiver goals that must be addressed during the delivery of family adaptive behavior treatment guidance (97156) to the member's legal guardian(s), and follow an evidence-based parent treatment curriculum. Generalized caregiver coaching services are not reimbursable; however, safety care training for families in a 1:1 setting are authorized when tied to IPOC goals related to addressing severe maladaptive behaviors.

Multiple-Family Group Adaptive Behavioral Treatment Guidance (97157)

Administered by a BCBA or BCaBA without the member present and two to six caregivers and/or sets of caregivers, not to exceed eight total participants. This face-to-face service uses behavior-analytic principles to approach identified skills and problem behaviors noted by the caregivers. The group service also provides a space for caregivers to practice procedures used at home and in

sessions with the member, allowing the qualified provider to offer suggestions and feedback. Requests for this service must include individualized goals that will be address in this setting.

Group Adaptive Behavior Treatment by Protocol, multiple patients, performed by a BCBA (97158)
Administered by a BCBA-D, BCBA or BCaBA with two to six members, utilizing a behavioral intervention protocol designed in advance by the BCBA or BCaBA. Requests for this service must include individualized goals that will be address in this setting

Service Documentation

Each treatment service delivered requires a clinical service note that identifies goals of the sessions, interventions provided, response of the member/family, and plan for next session. For group services, a group note individualized for each member or caregivers/caregiver set should be completed for each participant.

Staff-to-Member Ratio

All ABA treatment services shall be one-to-one unless specified otherwise in the service definition. All cases must include as part of the ABA treatment team a BCBA-D, BCBA or BCaBA.

Non-ABA ASD Treatment Services By A Licensed Independent Practitioner

Non-ABA ASD Treatment services can only be rendered by a LIP after receiving prior authorization once an IPOC has been submitted and approved. ASD treatment services are Evidence Based Practices (EBP) that support the amelioration and management of symptoms specific to the diagnosis of ASD. Direct member contacts (and collaterals as clinically indicated) are necessary for billable ASD Treatment Services. Non-ABA services must be provided by an independently licensed practitioner and cannot be rendered by an unlicensed practitioner who is under the supervision of a LIP.

Any changes in EBP offered must be documented in an IPOC change with rationale as to why the change was necessary for continued growth and development of the member. Emerging EBPs for ASD will be considered for prior authorization.

SCDHHS ASD SERVICES				
ABA Direct Assessment Services				
SERVICE NAME	CODE	PROVIDER/ SERVICE MODIFIER	UNIT FREQ	FREQUENCY LIMITS
Behavior Identification Assessment	97151	BCBA-D BCBA BCaBA	1 unit = 15 minutes	32 units annually, per member. Maximum of 12 units per day

Behavior Identification Supporting Assessment	97152	BCBA-D BCBA BCaBA RBT*	1 unit = 15 minutes	21 units per day, per member.
Behavior Identification Supporting Assessment—2 or more Technicians	0362T	BCBA-D BCBA BCaBA RBT*	1 unit = 15 minutes	16 units per day, per member. <i>Claim is based on total time elapsed, not total time per each technician</i>

ABA Direct Treatment Services				
SERVICE NAME	CODE	PROVIDER/ SERVICE MODIFIER	UNIT FREQ	FREQUENCY LIMITS
Adaptive Behavior Treatment by Protocol	97153	BCBA-D BCBA BCaBA RBT*	1 unit = 15 minutes	160 units per week, per member. <i>In any combination.</i>
Group Adaptive Behavior Treatment by Protocol	97154	BCBA-D BCBA BCaBA RBT*	1 unit = 15 minutes	2 – 6 patients, up to 6 hours a day.
Adaptive Behavior Treatment with Protocol Modification	97155	BCBA-D BCBA BCaBA GT = Via interactive video/audio telecommunication*	1 unit = 15 minutes	To be rendered up to a rate of 10% of rendered weekly therapy hours (97153), up to 64 units per month, per member. <i>*GT Modifier requires prior authorization, on a case by case basis</i>
Adaptive Behavior Treatment with Protocol Modification—2 or more technicians	0373T	BCBA-D BCBA BCaBA RBT*	1 unit = 15 minutes	32 units per day, per member. <i>Claim is based on total time elapsed, not total time per each technician. Must be billed by BCBA-D, BCBA, or BCaBA who is on site and administering treatment; service is in-person with patient.</i>
Family Adaptive Behavior Treatment Guidance	97156	BCBA-D BCBA BCaBA GT = Via interactive video/audio telecommunication	1 unit = 15 minutes	96 units annually, 24 hours a year, per member.

Multi-Family Group Adaptive Behavioral Treatment guidance – <i>without patient</i>	97157	BCBA-D BCBA BCaBA	1 unit = 15 minutes	16 units per day, per member. Group Ratio: 1 Provider:2-6 caregivers and/or sets of caregivers, not to exceed 8 total participants.
Group Adaptive Behavior Treatment by Protocol	97158	BCBA-D BCBA BCaBA RBT*	1 unit = 15 minutes	2-6 patients, up to 6 hours per day, per member.

Non-ABA Direct Treatment Services

SERVICE NAME	CODE	PROVIDER/ SERVICE MODIFIER	UNIT FREQ	FREQUENCY LIMITS
Non-ABA Treatment Services	H2019	Licensed Psychologist Licensed Psychoeducational Specialist Licensed Independent Social Worker-Clinical Practice Licensed Marriage and Family Therapist Licensed Professional Counselor	1 unit = 15 minutes	4 units per week, per member.

**RBT must bill under a BCBA-D, BCBA, or BCaBA.*

Developmental Evaluation Centers (DEC) Services

DECs are predefined entities that furnish a comprehensive and interdisciplinary array of developmental pediatric services. The emphasis of services performed by DEC facilities is placed on complex neurodevelopmental assessment and psychological evaluation provided to children under the age of 21 years who have developmental delays and have been referred to the DEC by their physician or other LPHA. These services may be supported by a licensed physician (MD/DO) or licensed psychologist (PhD/PsyD). Services may also be supported by a nurse practitioner (NP), PA, a school psychologist or LPES, LISW-CP under direct supervision of a licensed developmental and behavioral pediatrician or licensed psychologist. Services offered via telehealth are subject to the same duration requirements and service limits as services delivered face-to-face. Services delivered via telehealth should be billed with a 'GT' modifier, which can be the secondary modifier in instances where another modifier is required in the primary modifier position.

In determining medical necessity, DECs and DEC-affiliated community partners have the authority to utilize clinical judgment and current best practices in identifying the appropriate autism diagnostic and/or screening measures for specific members on a case-by-case basis; however, given the DEC focus of sub-specialized assessments of children with complex neurodevelopmental disorders, any

medical determinations and diagnoses must be made directly by licensed developmental and behavioral pediatricians, neurodevelopmental disabilities physicians and/or licensed psychologists.

Procedure codes listed below are reimbursed based on contracted rates for DEC's. DEC's may bill other procedure codes for services appropriate to them outside of the contract with SCDHHS when necessary to adhere to third party liability billing procedures

Developmental Evaluation Center Services			
Procedure Code	Description	Modifier	Units
T1023	<p>Neurodevelopmental Evaluation & Screening</p> <ul style="list-style-type: none"> • Board Certified/Board Eligible Developmental/Behavioral or Neurodevelopmental Disability Pediatrician • Comprehensive neurodevelopmental evaluation, suspected learning disorder, developmental delay, behavioral disorder, neurodevelopmental disability or other developmental/behavioral disorder. • Units of service may consist of evaluation activities involving the Developmental/Neurodevelopmental Pediatrician, General Pediatrician, Advance Practice Clinicians, Licensed Social Worker, RN or Fellow under direct supervision of Board Certified Developmental/Behavioral or Neurodevelopmental Disabilities Pediatrician. 	00, GT	30-minute units, 12 units per year, per member.
T1023 TF	<p>Neurodevelopmental Evaluation & Screening, Follow up</p> <ul style="list-style-type: none"> • Board Certified/Board Eligible Developmental/Behavioral or Neurodevelopmental Disability Pediatrician • Review of initial evaluation, testing & assessment activities, treatment plan changes, medical & pharmaceutical management, reports, team conferences, family conferences, & communicating treatment recommendations to parents, primary care providers and other professionals. • Units of service may consist of evaluation activities involving the Developmental/Neurodevelopmental 	TF, GT	30-minute units, 48 units per year, per member.

	Pediatrician, General Pediatrician, Advance Practice Clinicians, Licensed Social Worker, RN or fellow under direct supervision of Board Certified Developmental/Behavioral or Neurodevelopmental Disability Pediatrician.		
T1024	<p>Psychological Developmental Eval. and Screening</p> <ul style="list-style-type: none"> Licensed doctorate level psychologist Comprehensive psychological & developmental evaluation, suspected developmental, learning, or behavioral disorder. Services may consist of a comprehensive diagnostic interview, assessment of mental status & disposition, family history, review of medical/educational records, psychological testing, neuropsychological testing, review/analysis of performance indicators from developmental, cognitive, & psychiatric testing, consultation with allied health providers & educational personnel, family conferences, team conferences, report preparation & treatment recommendations. Units of service may consist of evaluation services performed by the doctorate level psychologist, master's level school psychologist, clinical psychology interns, or postdoctoral fellows under the supervision of a doctoral level psychologist. 	00, GT	30-minute units 24 units per year
T1024 TF	<p>Psychological Developmental Eval. and Screening, Follow up</p> <ul style="list-style-type: none"> Licensed doctorate level psychologist Psychological or neuropsychological testing to determine current psychological developmental status, mental status, updated family history, review of previous testing/reports, family conferences, team conferences, preparation of reports, and updating treatment recommendations. Units of service may be performed by a doctorate level psychologist, master's level school psychologist, clinical psychology intern, or postdoctoral psychology fellow under supervision of a doctorate level psychologist. 	TF, GT	30-minute units 24 units per year, per member.

G9004	<p>Coordination of Care, Scheduled Team Conference</p> <ul style="list-style-type: none"> Referrals, therapeutic, medical, educational & behavioral intervention services, coordination of care with other providers, and care coordination services necessary to implement plan of treatment. 		15-minute units, 24 units per year, per member.
G9011	<p>Coordination of Care, Risk Adjustment Maintenance, Level 5</p> <ul style="list-style-type: none"> Brief, solution-focused behavioral consultation and/or behavior management intervention provided by master's level social worker, doctoral level psychologist, master's level school psychologist, master's level psychology intern, postdoctoral psychology fellow, or board-certified behavior analyst to provide comprehensive care to established patient. 		15-minute units, 60 units per year, per member.

Medical Necessity Criteria to Determine Eligibility Criteria for ASD services

Medical necessity for ASD services must be determined following a direct, synchronous assessment that results in a DSM diagnosis of ASD, an IDEA designation that meets the SC Department of Education standard for the disability category of autism spectrum disorder, an eligibility determination under the autism category from the South Carolina Department of Behavioral Health and Developmental Disabilities Office of Intellectual and Developmental Disabilities (BHDD OIDD), or presumptive eligibility for ABA Therapy services. The clinician must document and attest that the assessment meets medical necessity criteria for ASD services under one of the following categories:

- Comprehensive Diagnostic Assessment for ASD
- Medical-Care-Home Autism Assessment
- Presumptive Eligibility Determination Assessment

Comprehensive Diagnostic Assessment for ASD

For members to be authorized for ASD services, the assessment must be administered directly by a licensed physician (MD/DO), licensed psychologist (Phd/PsyD), or LPES. Evaluations and results previously completed by the South Carolina Department of Education to establish school-based services under an IDEA category of ASD or for eligibility determinations under the ASD category by the SC Office of Intellectual and Developmental Disabilities, are considered valid regardless of the measures used in the assessment, must be incorporated into the CDA, and should not be repeated for confirmation of medical necessity for ASD services unless clinically indicated.

The comprehensive diagnostic assessment must be comprehensive with multiple informants when possible and cover multiple domains. The report must include documentation of the following:

- General member information including member's name, date of birth, date of assessment session(s), date of report, referral question, and reason for assessment.

- A comprehensive medical and clinical autism interview with the member and/or family members or guardians as appropriate, documenting a thorough medical and developmental history as well as a review of the presenting problems, symptoms and functional deficits, strengths, family support systems, and potential barriers to care. A history of exposure to physical, sexual and/or other trauma, antisocial behavior, and/or substance use should be documented where clinically appropriate. Additionally, behavioral rating scales are encouraged where clinically appropriate to assess the differential diagnosis.

- Review of past psychiatric treatment and psychological assessment, including documented review of tests administered, scores, risk levels, and diagnoses, as well as previous episodes of care in out-of-home placements and/or psychiatric hospitals.
 - **Note:** Clinician must document their request for all copies of any previous school-based psychoeducational evaluations, individualized education plans, behavioral intervention plans, or other plans outlining school accommodations. Results from these evaluations must be incorporated into the diagnostic assessment and should not be repeated to confirm medical necessity.

- An ASD diagnosis from the current edition of the DSM, including severity levels, indicated by completion of the DSM checklist, following a structured observation in one or more settings.

- Structured Observations must be supported by one of the following validated autism assessment tools administered directly by the licensed physician (MD/DO), licensed psychologist (PhD/PsyD), or LPES completing the assessment. Autism measures administered via Telehealth are not considered valid for determining medical necessity for ASD services:
 - Autism Diagnostic Interview (ADI-R)
 - Autism Diagnostic Observation Schedule (ADOS)
 - Childhood Autism Rating Scale (CARS)

- A clinically appropriate, standardized, cognitive or developmental measure, per the clinician's scope of practice, that addresses the role of global developmental disability or intellectual disability in the member's clinical presentation.

- Recommendations for additional services, support, or treatment based on medical necessity criteria, including specific subspecialty referrals to audiology, genetics, sleep medicine, and/or ENT, as needed, as well as any rehabilitative services (e.g., occupational therapy, speech therapy, etc.), and a referral to early intensive behavioral services (ABA, etc).

- The name of the licensed physician and physician specialty, licensed psychologist, or LPES, their professional title, signature with credentials, and date, as well as a signed attestation at the end of the clinical report affirming the physician, psychologist, or LPES directly administered the assessment.

Medical Care Home Autism Assessment

To better support provisions of the EPSDT program, the determination of medical necessity and full eligibility for ASD services may be made through a focused medical assessment by a physician within the child's medical care home. The Medical Care Home assessment is valid when the member's primary physician is:

- Confirming medical necessity of ASD services for a member with a pre-existing diagnosis or designation of Autism Spectrum Disorder as outlined below.
- Making an initial diagnosis of Autism spectrum disorder for a member between 18 to 36 months of age, who is medically uncomplicated and has unequivocal symptoms of autism spectrum disorder as outlined below.

Determining Medical Necessity for Members with Prior Evaluations

In confirming medical necessity for ASD services for a member of any age who has a prior established diagnosis/designation of autism, the physician must review the previously completed evaluation to ensure it meets diagnostic criteria.

- Prior evaluations completed as a result of multi-disciplinary eligibility determinations from the DOE and BHDD-OIDD that result in a category or designation of autism spectrum disorder are considered valid, regardless of the specific measures or clinicians involved to reach the eligibility determination.
- For all other prior evaluations, such as out-of-state or private evaluations, the report **MUST** meet the criteria outlined above for a CDA, to include administration of an in-person ADI/ADOS/CARS by a licensed physician, licensed psychologist, or LPES.
- ASD Diagnoses conferred by telehealth are not considered valid.
- In all situations involving a prior evaluation, the physician must incorporate the relevant evaluation results and a DSM checklist with severity levels into their clinical report/documentation, ensure the medical standard of care has been addressed, and place appropriate referrals for medically necessary services.
- A complete copy of the previous evaluation must be attached with the physician's clinical note, and a completed "Autism Diagnostic Tool for Physician Use in the Medical Care Home" form.

Making an Initial Diagnosis of ASD

A physician operating within the medical care home with verified training and certification in the administration of a validated secondary autism screener may make initial medical necessity

determinations for current members between the ages of 18-36 months of age who have unequivocal ASD symptoms following a two-tiered screening process. The clinical report should include all of the following:

- A detailed clinical Interview with the member and/or family members or guardians as appropriate, documenting a thorough medical and developmental history as well as a review of the presenting problems, symptoms and functional deficits, strengths, family support systems, and potential barriers to care. Behavioral rating scales are encouraged where clinically appropriate:
 - The clinical interview should clarify the member is medically uncomplicated and free of prenatal/neonatal complications, chronic medical conditions, and/or genetic conditions that are known to increase the member’s risk of neurodevelopmental disability and might prevent the physician from making an accurate diagnosis.
- The clinical interview should clarify that the member’s presentation is not complicated by past abuse, neglect, trauma, experience in foster care, homelessness, family resistance or disagreement with ASD diagnosis through a focused medical care home assessment, that might prevent the physician from making an accurate diagnosis:
 - The medical home-based assessment for ASD services should be deferred for members with complex medical or psychosocial presentations. Physician should proceed with a presumptive eligibility determination as described below and refer the member for a comprehensive diagnostic evaluation.

A documented physical exam. The child must not have any atypical or unique physical/facial/dermatologic features that may indicate underlying neurologic or genetic diagnoses that would indicate the need for a subspecialist evaluation.

- A standardized developmental screening or assessment, such as, but not limited to:
 - Ages and Stages Questionnaire (ASQ)
 - Parents' Evaluation of Developmental Status - Revised (PEDS-R)
 - Child Development Inventory (CDI)
- An “at-risk” score on a validated primary autism screening tool, such as:
 - Modified Checklist for Autism in Toddlers (MCHAT)
 - Communication and Symbolic Behavior Scales Developmental Profile – Infant/Toddler Checklist (CSBS-ITC)
 - Survey of Well-Being of Young Children: Parent’s Observations of Social Interactions (SWYC:POSI)
- Structured behavioral observations must be supported by one of the following:
 - Rapid Interactive Screening Test for Autism in Toddlers (RITA-T) with a total score of 18 or higher.

- Screening Tool for Autism in Toddlers and Young Children (STAT) with a total score of 3.0 or higher:
 - In the absence of other complicating factors, these scores indicate an exceptionally high likelihood of autism and secondary autism screeners are considered valid tools to support structured observations and a DSM diagnosis of ASD.
- A diagnosis from the current edition of the DSM, including severity levels, indicated by completion of the DSM checklist.
- Recommendations for additional services, support, or treatment based on medical necessity criteria and medical standard of care:
 - Referral to the State’s IDEA Part C program (required for children 18 to 34 months)
 - Referral to the member’s school district to assess the need for school-based services (required for children aged 30 to 36 months)
 - Referral to South Carolina’s Office of Intellectual and Developmental Disabilities (OIDD) (required for children aged 30 to 36 months)
 - Referral to Pediatric Audiology services or documentation of complete audiology evaluation (required)
 - Referral to Pediatric Genetics or documentation of a parent or caregiver's deferral of this recommendation.
 - Referral to clinically applicable rehabilitative therapies that the child is not already receiving, such as speech therapy, occupational therapy, and/or physical therapy
 - Referral for applied behavior analysis therapy if indicated.
- Completion of the Autism Diagnostic Tool for Physician Use in the Medical Care Home (See forms section).
- The licensed physician’s name, specialty, professional title, signature/credentials, and date, as well as a physician attestation to directly administering the assessment, and to the absence of complex neurodevelopmental factors that would necessitate referral for a comprehensive diagnostic assessment.

Presumptive Eligibility Assessment

Medicaid members at-risk for the development of autism spectrum disorder may be eligible for ABA services until their 6th birthday while awaiting a CDA or a Medical-Care-Home Assessment. Presumptive eligibility for ABA services is considered valid when the member has been determined to be presumptively eligible for ABA therapy through South Carolina’s IDEA Part C program and/or when an approved physician with verified training and certification in the administration of a validated secondary autism screener documents the following in their clinical note:

- The child is between the ages of 18 months and 36 months at the time of the assessment.
- An “At-Risk” score on a validated primary autism screener, and/or a brief clinical interview with a caregiver who reports behaviors and/or concerns for autism.
- An “At-Risk” score following physician administration of either:
 - Rapid Interactive Screening Test for Autism in Toddlers (RITA-T) with score ≥ 12
 - Screening Tool for Autism in Toddlers and Young Children (STAT) with score ≥ 2.00 .
 - Referral to Pediatric Audiology services or documentation of complete audiology evaluation, when co-occurring speech delay is present (required).
 - Referral to the state’s early intervention/IDEA Part C program (required for children aged 18 to 34 months)
 - Referral to clinically applicable rehabilitative therapies that the child is not already receiving; to include, speech therapy, occupational, and physical therapy.
 - › Important: Referral to rehabilitative therapies MAY be deferred to the child’s early intervention/IDEA Part C program service coordinator when patient is already established with BabyNet/IDEA Part C.
- Referral to the member’s school district to assess the need for school-based services through the SCDOE (required for children aged 30-36 months).
- Referral to a regional DEC or other practice/clinician capable of completing a comprehensive diagnostic assessment (CDA; required):
 - Important: Presumptive eligibility for ABA services will lapse without a documented DSM-supported diagnosis of autism spectrum disorder, per the criteria outlined above for a comprehensive diagnostic assessment or a medical-care home assessment, prior to the child’s 6th birthday.
- Clear documentation that counseling was provided to the parent/caregiver and they were advised of the following:
 - Presumptive Eligibility for ABA therapy is not a medical diagnosis of ASD, but an agreement to support ABA therapy due to a child’s documented risk for development of ASD.
 - Presumptive eligibility for ABA services does not automatically extend or affect eligibility for state-specific early intervention services, school-based services through the South Carolina Department of Education, or services through South Carolina’s Office of Intellectual and Developmental Disabilities. Each entity maintains its own eligibility process.
- To ensure ongoing eligibility for ABA services, their child must obtain a formal assessment that documents a DSM-supported diagnosis of autism spectrum disorder, prior to their child’s 6th birthday.
- Completion of the Presumptive Eligibility Tool for Physician Use in the Medical Care Home (see forms section).

DRAFT