SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

AUTISM SPECTRUM DISORDER (ASD) SERVICES PROVIDER MANUAL

JANUARY 1, 2025

South Carolina Department of Health and Human Services

CONTENTS

1

PROGRAM OVERVIEW

Services to treat Autism Spectrum Disorder (ASD), as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), are provided to eligible Medicaid beneficiaries ages 0 to 21. ASD services must be recommended by a Licensed Psychologist, Developmental Pediatrician, or a Licensed Psycho-Educational Specialist (LPES) within his or her scope of practice under the South Carolina State law to prevent the progression of ASD, prolong life, and promote the physical and mental health and efficacy of the individual. These services may be provided in the beneficiary's home, clinical setting, or other settings as authorized in the applicable section of the South Carolina Department of Health and Human Services (SCDHHS) Provider Manual.

ASD Treatment Services include a variety of behavioral interventions. SCDHHS recognizes those behavioral interventions that are identified as evidence-based by nationally recognized research reviews, and those identified and supported with substantial scientific and clinical evidence.

The purpose of this manual is to provide pertinent information to ASD service providers for participation in the South Carolina Medicaid program. This manual provides a comprehensive overview of the ASD service provider policy and procedure for Licensed Independent Practitioners (LIPs), Board Certified Behavior Analyst - Doctoral level (BCBA-D), Board Certified Behavior Analyst – Master's level, Board Certified Assistant Behavior Analyst (BCaBA), and Registered Behavior Technicians (RBTs) or Behavior Technicians (who will be RBT certified within 90 days of employment) rendering ASD treatment services.

SCDHHS requires the use of evidence-based practices in the context of a system that ensures thorough and appropriate screening, evaluation, diagnosis and treatment planning, and fosters improvement in the delivery system of mental health services to children in the most effective and cost-efficient manner. Evidence-based practices (EBP) are defined as mental and behavioral health interventions for which systematic empirical research has provided evidence of statistically significant effectiveness as treatments for specific problems. Approved evidence-based practices for ASD treatment are listed in the ASD-covered services section of this manual.

ASD services must be determined medically necessary to be eligible for Medicaid reimbursement and all services must be authorized prior to service delivery.

The requirements for prior authorization are articulated later in this section. Failure to obtain authorization prior to provision of service when required will result in non-payment.

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.

As a condition of participation in the Medicaid program, the provider must ensure that adequate records are kept disclosing the extent of services provided for members. Claims submitted for services rendered must be in accordance with all applicable laws, regulations and policies.

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
- Section 4 - Procedure Codes

2

COVERED POPULATIONS

ELIGIBILITY/SPECIAL POPULATIONS

Eligibility for Services

The determination of eligibility for ASD services requires a comprehensive psychological assessment/testing report for the beneficiary.

Unless otherwise specified in the specific service description, Medicaid-eligible beneficiaries may receive ASD services by an ASD network provider when there is a primary psychiatric diagnosis of ASD from the current edition of the DSM, and services are determined medically necessary. Beneficiaries who meet this criterion must be under the age of 21.

Providers must verify current eligibility and Third Party Liability (TPL) status prior to service delivery. Gaps in Medicaid eligibility may result in a referred beneficiary being ineligible for Medicaid coverage at the time of treatment.

Medical Necessity

All Medicaid beneficiaries must be under the age of 21 and have an established ASD diagnosis to meet medical necessity criteria in order to receive ASD treatment services.

Documenting Medical Necessity

A Licensed Psychologist, Developmental Pediatrician or a Licensed Psycho-Educational Specialist (LPES) certified by the South Carolina Department of Education to perform such evaluations, and acting within the scope of their competency, must certify and document through a comprehensive psychological assessment/ testing report that the beneficiary meets the medical necessity criteria for services via a DSM ASD diagnosis.

Comprehensive Psychological Assessment/Testing Report

For new beneficiaries receiving ASD services, comprehensive psychological assessment/testing report must include:

1. A clinical interview with the beneficiary and/or family members or guardians as appropriate.
2. A review of the presenting problems, symptoms and functional deficits, strengths and history, including past psychological assessment reports and records.
3. Assessments also include a behavioral observation in one or more settings.
4. Autism Diagnostic Observation Schedule (ADOS).

5. A standardized measure of intelligence (e.g., WISC or WAIS, Stanford-Binet, Bayley Scales, etc.).

6. An ASD diagnosis from the current edition of the DSM, including severity levels.

Assessments may also include one or more of the following*:

- Autism Diagnostic Interview (ADI)
- Behavior Assessment System for Children (BASC)
- Childhood Autism Rating Scale (CARS)
- Gilliam Autism Rating Scale (GARS)
- Vineland Adaptive Behavioral Scales (Vineland)
- Assessment of Basic Language and Learning Skills (ABLLS-R)
- Social Responsiveness Scale (SRS)
- Screening checklists (e.g., MCHAT, STAT, ASQ, etc.)
- Social Communication Questionnaire (SCQ)

** Please note that while the list is not exhaustive, the measures utilized must be standardized.*

Service Documentation

The comprehensive psychological assessment/testing report must include the following information:

- The beneficiary's name and date of birth.
- The date of evaluation session(s) and date of the report.
- Referral question and/or reason for assessment.
- Administered tests.
- Medical history and medications.
- Family history.
- Psychological and/or psychiatric treatment history including previous psychological assessment/testing reports, etc.

- Substance use history.
- Beneficiary and/or family strengths and support system.
- Exposure to physical abuse, sexual abuse, anti-social behavior or other traumatic events.
- A diagnosis from the current edition of the DSM, including levels of severity.
- Recommendations for additional services, support, or treatment based on medical necessity criteria, including specific rehabilitative services (e.g., occupational therapy, speech therapy, etc.).
- The name of the Psychologist, LPES or Developmental Pediatrician; professional title, signature, and date.

Beneficiaries with a Prior Established Diagnosis

A prior-established diagnosis is acceptable provided the comprehensive psychological assessment/testing report adheres to the medical necessity guidelines. The following guidelines must be used to determine medical necessity:

- In addition to a behavioral observation and caregiver clinical interview, acceptable instruments to establish an ASD diagnosis must include at least three of the following, one of which must be an ASD-specific diagnostic tool:
  - ADOS
  - ADI
  - CARS
  - GARS
  - Vineland
  - ABLLS-R
  - SRS
  - BASC
  - SCQ
  - A standardized measure of intelligence (e.g., WISC or WAIS, Stanford-Binet, Bayley Scales, etc.)

- Screening checklists (e.g., MCHAT, STAT, ASQ, etc.)

The comprehensive psychological assessment/testing report must also include the following information:

- The beneficiary's name and date of birth.
- The date of evaluation session(s) and date of the report.
- Referral question and/or reason for assessment.
- Administered tests.
- A psychiatric diagnosis from the current edition of the DSM or the International Statistical Classification of Diseases and Related Health Problems (ICD).
- The name of the Psychologist or LPES, professional title, signature and date.

If SCDHHS or its designee determines that services were reimbursed when there were no valid medical necessity components listed in the assessment and/or Individualized Plan of Care (IPOC), the provider payments will be subject to recoupment.

Presumptive Diagnosis for Beneficiaries under the Age of Four

Psychological assessments conducted prior to a beneficiary's fourth birthday must reflect a presumptive diagnosis. Assessments must include observation of behavior in multiple settings and a clinical interview with parents, guardians, and/or other significant individuals involved in the child's care. A beneficiary must have a comprehensive psychological assessment/testing report documenting that the beneficiary meets the medical necessity criteria for services via a DSM ASD diagnosis by a Licensed Psychologist, School Psychologist or Developmental Pediatrician by the beneficiary's fourth birthday.

3

ELIGIBLE PROVIDERS

PROVIDER QUALI FICATIO NS

To participate in the South Carolina Medicaid program, providers must qualify as Medicaid LIP providers or be enrolled as a BCBA or BCaBA.

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

- A Licensed Psychologist
- A Licensed Psycho-Educational Specialist (LPES)
- A Licensed Independent Social Worker - Clinical Practice (LISW-CP)
- A Licensed Marriage and Family Therapist (LMFT)
- A Licensed Professional Counselor (LPC)
- Board Certified Behavior Analyst-Doctoral (BCBA-D)
- Board Certified Behavior Analyst (BCBA)
- Board Certified Assistant Behavior Analyst (BCaBA)

Providers of ASD services must have appropriate education, experience, and have passed prerequisite examinations as required by the applicable State laws and licensing and/or certification board. Additional requirements are established by SCDHHS and are referenced within this manual.

The presence of licensure and/or certification means the established licensing board in accordance with South Carolina Code of Laws has granted the authorization to practice in the State. Licensed professionals must maintain a current license and/or certification from the appropriate authority to practice in the State and must be operating within their scope of practice. The presence of a Behavior Analyst Certification Board (BACB) certification means the Board has granted authorization for certified providers to practice and operate within their scope or practice. Following BACB guidelines, case supervision must be provided by a BCBA or BCaBA.

All ASD providers must comply with all guidelines and procedures required by their respective licensing and/or certification boards.

Provider Qualification Table

Credential	PROVIDER QUALIFICATIONS
BCBA-D	BCBA-D is the doctoral designation for a BCBA with doctoral training in behavior analysis. BCBAs supervise the work of BCaBAs, RBTs and others who implement behavior-analytic interventions.
BCBA	A BCBA has a graduate-level certification in behavior analysis. BCBAs supervise the work of BCaBAs, RBTs and others who implement behavior-analytic interventions.
BCaBA	A BCaBA has an undergraduate-level certification in behavior analysis. BCaBAs must be supervised by someone certified at the BCBA-D/BCBA level. BCaBAs can supervise the work of RBTs and others who implement behavior-analytic interventions.
RBT	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. 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.
Behavior Technician	A paraprofessional who practices under the supervision of a BCBA-D, BCBA or BCaBA. The Behavior Technician is primarily responsible for the direct implementation of the behavior-analytic services. The individual supervising the Behavior Technician is responsible for the work performed by the Behavior Technician. 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 90-day period to acquire an RBT credential from the day of hire.
Licensed Psychologist LPES LISW-CP LMFT LPC	Please see LIP Manual for LIP provider qualifications.

Maintenance of Autism Spectrum Disorder 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 fee-for-service (FFS) and Managed Care Organization (MCO) members.

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

Applied Behavior Analysis (ABA) providers must ensure that all BCaBAs, RBTs, and Behavior Technicians that require supervision are under the authority of a qualified provider acting within their competency scope and are properly qualified, trained and supervised.

All Medicaid-enrolled groups or schools must maintain a file substantiating each practitioner's qualifications and training. This must include employer verification of the ASD provider's licensure and/or board certification and work experience. The group must maintain a signature sheet that identifies all professionals providing services by name, signature and initial.

In addition to documentation of ASD network provider credentials and training, the group or school 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 the South Carolina Law Enforcement Division (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.
- Results of the child abuse registry checks should not indicate any findings or criminal charges against an individual.

Note: *The report must be updated annually.*

LIP(s) must be licensed to practice in the State where they are providing services and must not exceed their licensed scope of practice under State law.

ABA providers must be certified by the BACB and must not exceed their certified scope of practice.

Managed Care Organizations

ASD services are covered for beneficiaries enrolled in a Medicaid MCO. If the beneficiary is enrolled in a MCO, the provider must request prior authorization and claim reimbursement from the MCO directly.

In addition to the policies contained herein, MCOs may place further requirements on their contracted ASD providers.

Providers are encouraged to visit the SCDHHS website at: https://www.scdhhs.gov/resources/health-managed-care-planshttps://msp.scdhhs.gov/managedcare/ for additional information regarding MCO contracting and coverage.

Business Termination Guidelines

In the event the LIP or ABA provider closes his or her practice, the provider will adhere to all of the following applicable State laws, rules and regulations:

- In cases of voluntary termination or closure, the provider must provide written notification 30 days prior to the closure, to SCDHHS and other appropriate agencies.
- The notification must include the location where beneficiary and administrative records will be stored.
- The responsible party must retain administrative and beneficiary records for five years.
- Prior to closure, the LIP or ABA provider will notify all beneficiaries and assist them in locating appropriate service providers.
- When a provider closes, the owner is responsible for releasing records to any beneficiary who requests a copy of his or her records. The owner is also responsible for the transfer of records to the appropriate State agencies, if applicable.
- Even if a provider closes, the provider may be responsible for repayment of any overpayments that occurred during the time the provider rendered treatment to Medicaid beneficiaries.
- If the provider is terminated involuntarily by Medicaid, the provider is responsible for all beneficiary and administrative records in the event of a post-payment review.

Referral Process

There are four ways that an ASD network provider may receive a referral to provide services:

- A Medicaid-enrolled physician or Licensed Practitioner of the Healing Arts (LPHA) may refer an eligible beneficiary to an ASD network LIP for a comprehensive psychological assessment/ testing report to establish an ASD diagnosis and medical necessity.

- An eligible Medicaid beneficiary may self-refer to an ASD network LIP for a comprehensive psychological assessment/testing report to establish an ASD diagnosis and medical necessity.
- A Medicaid-enrolled physician or LPHA may refer an eligible beneficiary with a prior-established ASD diagnosis to an ASD-network LIP or ABA provider for ASD treatment services.
- An eligible Medicaid beneficiary with a prior-established ASD diagnosis may self-refer to an ASD-network ABA or LIP for ASD treatment 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 the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

Staff-to-Beneficiary Ratio and Case Load Management

Staff-to-beneficiary ratios are established for safety and therapeutic efficacy concerns. Ratios must be met and maintained at all times during hours of operation.

Staff should be in direct contact and be involved with the beneficiary 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-beneficiary ratios:

- LIPs must maintain a one-to-one staff-to-beneficiary ratio throughout treatment.
- ABA providers must maintain at least a one-to-one staff-to-beneficiary ratio throughout treatment, with the exception of group adaptive behavior treatment. Additionally, ABA providers must adhere to the following caseload ratio:
  - BCBAs (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 16 cases.
  - Caseload counts are dependent on the amount of therapy provided:
    - 30–40 hours per week = one case

- 10–25 hours per week = ½ case
- < 10 hours per week = ¼ case

PROVIDER MEDICAID ENROLLMENT AND LICENSING

Autism Spectrum Disorder Provider Enrollment Guidelines

All Medicaid Provider Enrollment is completed through an online enrollment application process. Please refer to the resources available on the Provider Enrollment website at: https://www.scdhhs.gov/ProviderRequirements for complete instructions.

LIP Provider Enrollment Guidelines

LIP providers must fulfill all requirements for South Carolina licensure as promulgated by the South Carolina Code of Laws and established and enforced by the South Carolina Department of Labor, Licensing and Regulation.

Prior to completing the online enrollment application, all first-time LIP applicants must complete the following steps to become enrolled as a Medicaid provider:

- Obtain a National Provider Identifier (NPI) number. A NPI number is required to enroll directly with the Medicaid program. Information about the NPI number is available on the Centers for Medicare and Medicaid Services (CMS) website at https://nppes.cms.hhs.gov.
- Register for the pre-enrollment orientation at https://training.scdhhs.gov/academy/course/view.php?id=5. The pre-enrollment orientation is available online 24 hours per day, seven days per week. The orientation is designed to provide the LIP with knowledge about policy and procedures and prevent potential Medicaid recoupment because of a post-payment review. Following the orientation, the LIP will be prompted to complete a questionnaire.
- Complete the online provider enrollment application. On the application, providers must select “New Enrollment” and the following options:

LIP ENROLLMENT OPTIONS — INDIVIDUAL	
Enrollment Type	Organization
Provider Type Description	Other Medical Professionals
Specialty Description (Select one specialty)	LISW-CP, LPC, LMFT, LPES, or Psychologist
Subspecialty Description	No Subspecialty

LIP group practices must enroll separately and receive a Medicaid Group Legacy ID number. Please refer to the Provider Administrative and Billing Manual for information on fees associated with this type of enrollment. Each LIP wishing to render Medicaid reimbursable services through a group practice must also be enrolled individually with Medicaid and can affiliate themselves during their online application process with a currently enrolled group practice.

To enroll as a LIP Group, select “New Enrollment” and the following options:

LIP ENROLLMENT OPTIONS — ORGANIZATION	
Enrollment Type	Organization
Provider Type Description	Groups
Specialty Description (Select one specialty)	LISW-CP, LPC, LMFT, LPES, Psychologist or Multiple Specialty Group
Subspecialty Description	No Subspecialty

Entering the Medicaid Group National Provider Identifier (NPI) number on the Medicaid billing form (CMS-1500) will ensure that payment is made to the group rather than to the individual LIP.

Please refer to the Provider Administrative and Billing Manual for instructions regarding billing procedures.

A prior enrolled Medicaid LIP is eligible to provide therapy services once approved by SCDHHS. Each LIP must submit an ASD LIP Provider Application to: asdprovider@scdhhs.gov, and receive approval from SCDHHS to provide approved evidence-based practices. A blank ASD LIP Provider Application can be found on the SCDHHS provider portal.

ABA Provider Enrollment Guidelines

ABA applicants must complete the following steps to become enrolled as a Medicaid provider:

- Obtain an NPI number:
  - An NPI number is required to enroll directly with the Medicaid program. Information about the NPI number is available on the Centers for Medicare and Medicaid Services (CMS) website at: https://nppes.cms.hhs.gov.
- Complete the online Provider Enrollment application.

- Group providers must ensure they enroll the group NPI; however, they must also enroll each individual BCBA and/or BCaBA.

- On the application, providers must select “New Enrollment” and the following options depending on whether enrolling an individual or a group:

ENROLLMENT TYPE	PROVIDER TYPE DESCRIPTION	SPECIALTY DESCRIPTION	TAXONOMY CODE
Individual	Other Medical Professionals	Board Certified Behavior Analyst	103K00000X
Individual	Other Medical Professionals	BCaBA	106E00000X

ASD Group Provider Enrollment Guidelines

ABA group practices must enroll separately. Group providers not having a group NPI will need to request a new NPI with the National Plan & Provider Enumeration System (NPPES). Groups must enroll with one of the following:

ENROLLMENT TYPE	PROVIDER TYPE DESCRIPTION	PROVIDER SPECIALTY	TAXONOMY CODE
Organization	Groups	Multiple Specialty Group	193200000X
Organization	Groups	Single Specialty Group	193400000X

Linking Individual Providers to Group Providers

In order to link an existing individual provider to an existing group provider, a representative must send a signed letter on company letterhead, indicating all of the BCBA and BCaBA providers who need to be linked to the group number. Include the individual provider numbers on the letter. Submit this letter to asdprovider@scdhhs.gov.

Note: Failure to link providers may result in claims denial.

School Districts

School Districts that provide these services will need to enroll with SCDHHS as an ASD group provider as outlined in the above table. The School District requesting to enroll as an Autism provider will need to request a new NPI with the National Plan and Provider Enumeration System (NPPES).

School Districts must link each approved individual BCBA or BCaBA therapist to the new School District group. In addition, each individual School District therapist will be enrolled as an individual as described in the ABA Provider description above.

If School District providers choose to furnish services outside the school setting, for example, in a private practice setting, the individual School District BCBA or BCaBA provider must complete individual enrollment as per the individual ABA provider guidelines above in order to bill privately for ASD treatment services

4

COVERED SERVICES AND DEFINITIONS

COVERED SERVICES AND DEFINITIONS

Service Location

See the Provider Administrative and Billing Manual for approved places of service.

Service Documentation

All service documentation for ASD providers must be retained in either hard copy or electronic format based on the rules indicated in the Provider Administrative and Billing Manual.

Non-Applied Behavioral Analysis Autism Spectrum Disorder 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 EBP that support the amelioration and management of symptoms specific to the diagnosis of ASD. Direct beneficiary 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.

Allowable EBPs for ASD treatment services by a LIP include:

- Cognitive Behavioral Intervention Package
- Comprehensive Behavioral Treatment for Young Children
- Language Training (Production)
- Modeling
- Naturalistic Teaching Strategies (NTS)
- Parent Training Package
- Peer Training Package
- Pivotal Response Treatment®
- Schedules
- Scripting

- Self-Management
- Social Skills Package
- Story-Based Interventions

Further information can be found at the National Professional Development Center on Autism Spectrum Disorder at: http://autismpdc.fpg.unc.edu/evidence-based-practices.

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 beneficiary.

Emerging EBPs for ASD will be considered for prior authorization.

Staff-to-Beneficiary Ratio
ASD treatment services with a LIP should be furnished one-on-one with the beneficiary and the addition of collaterals as necessary.

Autism Spectrum Disorder Services by an Applied Behavior Analysis Provider

Assessments are to be completed by a BCBA or BCaBA. Assessments may include direct observation and measurement of beneficiary behavior in structured and unstructured situations, determination of baseline levels of adaptive and maladaptive behaviors and functional behavior analysis. The following service descriptions are based on the Current Procedural Terminology (CPT) coding guidelines.

Applied Behavior Analysis Assessment Services

Assessment for IPOC Development

Behavior Identification Assessment

Administered by BCBA or BCaBA, face-to-face with patient and caregiver(s). Includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s) and preparation of a report.

This service must include the following assessments:

- Vineland
- At least two of the following:
    - Pervasive Developmental Disorder Behavioral Inventory
    - Social Responsiveness Scale
    - Promoting the Emergence of Advanced Knowledge - Comprehensive Assessment

- Verbal Behavior Milestones Assessment and Placement Program
- Assessment of Functional Living Skills
- Essentials for Living
- Assessment of Basic Language and Learning Skills

Behavior Identification Supporting Assessment – One Technician

Administered by a RBT under the direction of a physician or other qualified provider, this face-to-face service gathers information that supports the identification of problematic or target behaviors noted in the initial assessment conducted by the BCBA or BCaBA.

This assessment service may be provided at multiple points in ABA services, to include the following:

- After the BCBA/BCaBA's initial assessment;
- After progression of therapy for the purpose of re-assessment to refine treatment goals and gauge effectiveness of interventions;
- 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;
- After a specific intervention or therapy module, a targeted post-intervention assessment may identify the effectiveness of the specific intervention or protocol.

Behavior Identification Supporting Assessment – Two or More Technicians

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.

**"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, 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-Beneficiary Ratio

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

Applied Behavior Analysis 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 Behavior Technician in accordance with their competency parameters, as per the BACB. BCaBAs and RBTs furnishing services must be under the direct supervision of a BCBA within their scope of competency.

Authorized synchronous audio/visual supervision of RBTs and other therapists is available using telehealth for established patients. 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

Administered by a technician face-to-face with one beneficiary under the direction of a BCBA or BCaBA, utilizing a behavioral intervention protocol designed in advance by the BCBA or BCaBA.

Group Adaptive Behavior Treatment by Protocol, multiple patients, performed by a BCBA

Administered by a BCBA or BCaBA with two or more beneficiaries, utilizing a behavioral intervention protocol designed in advance by the BCBA or BCaBA.

Group Adaptive Behavior Treatment by Protocol, multiple patients, performed by a RBT and administered by an RBT under the direction of a qualified healthcare professional, with two or more beneficiaries, utilizing a behavioral intervention protocol designed in advance by the BCBA or BCaBA.

Adaptive Behavior Treatment with Protocol Modification

Administered by a BCBA or BCaBA face-to-face with a single beneficiary. 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.

Adaptive Behavior Treatment with Protocol Modification –Two or More Technicians

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

- 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.

**"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, BCaBA).

Limitations

This service may not be billed concurrently with Adaptive Behavior Treatment with Protocol Modification.

Family Training

Family Adaptive Behavior Treatment Guidance

Administered by a BCBA or BCaBA with guardian(s)/caregiver(s), without the presence of a beneficiary, and involves identifying behaviors and deficits and teaching guardian(s)/caregiver(s) of one beneficiary to utilize treatment protocols designed to reduce maladaptive behaviors and/or skill deficits.

Multiple-Family Group Adaptive Behavioral Treatment Guidance

Administered by a BCBA or BCaBA without the member present and two or more caregivers/caregiver sets, 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.

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-Beneficiary 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 or BCaBA.

DEVELOPMENTAL EVALUATION CENTERS SERVICES

Developmental evaluation centers (DEC) furnish a comprehensive array of developmental pediatric services. The emphasis of services performed are neurodevelopmental assessments and psychological evaluations provided to children under the age of 21 years who have developmental delays and have been referred by a physician or other LPHA. These neurodevelopmental assessment and psychological evaluation services are available via telehealth when provided by a physician, nurse practitioner (NP), physician assistant (PA), or 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.

Telehealth Overview

The Centers for Medicare and Medicaid Services (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 Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant. DHHS 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

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

Synchronous telehealth is real-time, audio-video communication that connects physicians and patients in different locations (referring site and consulting site).

Referring Provider

The referring provider is the provider who has evaluated the beneficiary, 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

The consulting provider is the provider who evaluates the beneficiary 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 Medicaid program are eligible to bill for covered Medicaid services via telehealth in accordance with SCDH

- HS coverage policies and the provider’s scope of practice. Both the referring and the consulting providers must be enrolled in the South Carolina Medicaid program.

Referring Sites

A referring site (also called the patient site) is the location of an eligible Medicaid beneficiary at the time of the telehealth session. Medicaid beneficiaries 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, NP, CNM, PA, or LIP
- Hospital (inpatient and OP)
- RHCs
- 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 board and their scope of practice.

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

- Physicians
- NPs
- PAs
- Licensed Independent Practitioners (and associates)
- Physical, occupational, and speech therapists
-

Covered Services

Services that are eligible for reimbursement include supervision of RBTs and other therapists via a telecommunication system and neurodevelopment assessment and psychological evaluation services rendered by DEC providers. A licensed physician, NP, PA, licensed psychologist, licensed professional counselor may provide services via telehealth.

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

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

- The beneficiary 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 beneficiary. 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 beneficiary 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 beneficiary 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 beneficiary 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 beneficiary 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 beneficiary'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 services are not reimbursable by Medicaid:

- Court appearances
- Supervision/staffing
- Mileage/driving time
- Completing/amending a Medicaid billing form.
- Any contact on behalf of a non-referred Medicaid beneficiary.
- Telephone contact related to office procedures or appointment time.
- Consultation for beneficiaries who are not involved in an ongoing assessment or treatment.
- Consultation performed by persons supervised by an ASD network provider.
- Services of an experimental, research, or unproven nature, or services in excess of those deemed medically necessary.
- Biofeedback
- Hypnotherapy
- Sensitivity Training
- Encounter groups or workshops
- Canceled appointments or appointments not kept
- Court testimony

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 at: (888) 289-0709. You may also submit an online inquiry at https://www.scdhhs.gov/providers/contact-provider-representative.

5
UTILIZATION MANAGEMENT

PRIOR AUTHORIZATION

Medicaid FFS beneficiaries must receive prior authorization from the SCDHHS' designated QIO, KEPRO. 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 services must be determined medically necessary and have a prior authorization by the QIO. Managed care prior authorizations must go through the member's respective MCO.

For all FFS beneficiaries, all prior authorizations will be valid for a period of six months.

To receive reimbursement from Medicaid, all FFS prior authorization requests must be faxed to or submitted via the QIO web portal for approval. The Outpatient Prior Authorization Request Form KEPRO — SCDHHS QIO can be found on the QIO website at: .https://scdhhs.acentra.com/ The Prior Authorization Request Form must be submitted to the QIO with the required documentation outlined below. 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.

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. If SCDHHS or its designee determines that services were reimbursed when there was not a valid approval letter in the beneficiary's file, the provider payments will be subject to recoupment.

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

Fax: (855) 300-0082
Web Portal: https://scdhhs.acentra.com/

If using the web portal, the provider can download the approval document(s). The approval document(s) must be placed in the beneficiary's clinical record prior to or at the time of the appointment for treatment. A faxed copy is acceptable.

The provider may contact the QIO using one of the following methods:

Customer Service: (855) 326-5219

Fax: (855) 300-0082
Provider Issues Email: atrezzoissues@KEPRO.com

Prior Authorization for LIP Provider
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 comprehensive psychological assessment/testing report and 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 Provider
Once medical necessity is established and the Behavior Identification Assessment is completed, the following services may be authorized to be provided by ABA providers:

- Adaptive Behavior Treatment by Protocol
- Adaptive Behavior Treatment with Protocol Modification
- Family Adaptive Behavior Treatment Guidance

For initial treatment requests, the comprehensive psychological assessment/testing report, Behavior Identification Assessment results, and IPOC must be submitted to the QIO along with the SCDHHS ASD Prior Authorization Request Form.

If service authorizations do not meet the needs of the beneficiary, 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 beneficiary 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.

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.

For annual treatment reviews, new Behavior Identification Assessment results, updated IPOC and progress summary spanning the previous authorized treatment period must be submitted to the QIO with the SCDHHS ABA Prior Authorization Request Form. 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 beneficiary's Medicaid member 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).

LIPs, ABA and/or school 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 beneficiary 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, beneficiary's rights and responsibilities, retention procedures and code of ethics.

6

REPORTING/DOCUMENTATION

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 beneficiary, but not simultaneously.
- Program supervision must be provided in accordance with BACB guidelines (one hour of direct supervision for every ten hours of therapy).
- 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 contacts per month, during at least one of which the supervisor observes the RBT providing 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 beneficiary:
  - 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 from the day of hire.
- The Behavior Analyst (BCBA or BCaBA) will be responsible for continuity of care regarding beneficiaries who are under the care of technicians who do not obtain an RBT credential within 90 days.

Clinical Records and Documentation Requirements

Each ASD network provider must maintain a clinical record for each beneficiary that fully describes the extent of the treatment services provided. The clinical record must contain documentation

sufficient to justify Medicaid reimbursement and should allow an individual not familiar with the beneficiary to evaluate the course of treatment. Providers must maintain records as outlined in the Provider Administrative and Billing Manual for all MCO members.

The absence of appropriate and complete records may result in recoupment of payments by SCDHHS.

Each provider must have the responsibility of maintaining accurate, complete, and timely records and should always adhere to procedures to ensure confidentiality of clinical data. All clinical documentation must be signed by either the enrolled BCBA, BCaBA or the LIP as applicable.

The beneficiary's clinical record must include, at a minimum, the following documentation:

- A Comprehensive Assessment/Testing Report which establishes medical necessity via an ASD diagnosis.
- A Behavioral Identification Assessment for ABA services (if applicable).
- Signed, titled and dated IPOC.
- Signed releases, consents, Beneficiary Rights acknowledgment, and confidentiality assurances for treatment.
- Signed, titled and dated clinical service note (CSN) and progress summaries.
- Copies of all written reports, and any other documents relevant to the care and treatment of the beneficiary.

Consent for Treatment

A consent form dated and signed by the beneficiary, parent, legal guardian or primary caregiver (in cases of a minor), or legal representative must be obtained at the onset of treatment from all beneficiaries and documented in the beneficiary's clinical records. If the beneficiary is accompanied by next of kin or a responsible party, and the beneficiary is unable to sign the consent form due to a marked deterioration in functioning, the next of kin or responsible party may sign the consent form.

A new consent form should be signed and dated with every new prior authorization, whenever a service is added, and/or each time a beneficiary is readmitted to services after discharge.

Transition, Discharge and Continuity of Care

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

Transition and discharge planning must include a written plan containing specific details of monitoring and follow-up. Parents, caregivers and other involved professionals should be consulted

3–6 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 beneficiary and family members. Transition and discharge planning from all treatment programs should involve a gradual step down in services over six months or longer.

Beneficiaries 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.
- Beneficiary requests discharge (and is not imminently dangerous to self or others).
- Beneficiary requires a higher level of care (i.e., inpatient hospitalization or Psychiatric Residential Treatment Facility).
- Beneficiary reaches age 21.

Coordination of Care

SCDHHS expects coordination of care and continued communication between the referring physician or State agency and the ASD network provider. There should be evidence in the record of clinically appropriate coordination between the ASD network provider, the referring entity regarding treatment, and the beneficiary'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 beneficiary's overall care.

Emergency Safety Intervention

The Emergency Safety Intervention (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 beneficiary 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 beneficiary 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)

All ASD treatment services must be documented in CSN within five business days of their delivery. CSN can be documented via hard copy or electronically. Providers serving MCO members must retain records as described in the Provider Administrative and Billing Manual. Each discrete service should have its own CSN capturing service and bill time. ABA providers must document in accordance with ABA standards and guidelines. All other providers' CSN must include the nature of the beneficiary's treatment, any changes in treatment, discharge, crisis interventions and any changes in medical, behavioral or psychiatric status. Documentation must justify the amount of reimbursement claimed to Medicaid.

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) from the IPOC toward which the session is focused.
- The structured activities of the beneficiary in the session.
- The beneficiary's response to the intervention/ treatment.
- The specific intervention(s) used.
- The beneficiary's progress or lack of progress made in treatment.
- Recommendation and future plans for working with the beneficiary.

Medicaid considers the ASD network provider's signature on clinical documentation as an attestation to the accuracy of the diagnoses, treatment modalities and claims submitted for all Medicaid beneficiaries.

Additionally, the following requirements must be met in order for an ASD network provider to comply with Medicaid documentation policy. ASD network providers should review each requirement listed below to ensure that services are not subject to recoupment. All CSN must include:

- The beneficiary's name and Medicaid ID.
- Date of service.
- Name of the service provided.
- Place of service.
- Duration of service (start and end time for each service delivered).
- Be typed or handwritten using only black or blue ink.
- Be legible and kept in chronological order.
- Reference individuals by full name, title and agency/provider affiliation at least once in each note.
- Be signed, titled and signature dated (month/date/year) by the LIP or ABA provider responsible for the provision of services. The signature verifies that the services are provided in accordance with these standards.
- Be completed and placed in the clinical record following service delivery but no later than five business days from the date of service.

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

Individualized Plan of Care

The IPOC is a comprehensive plan of care outlining the service delivery that will address the specific strengths and needs of the beneficiary. The IPOC must be individualized and specify problems to be addressed, goals to be worked toward and the strengths of the beneficiary. Goals should include the generalization of skills to beneficiaries' home and communication environment. The IPOC must be developed prior to the delivery of a service with the full participation of the beneficiary and his or her family. Prior authorization for treatment services can be provided after an IPOC has been completed.

The IPOC will be person/family centered and the beneficiary must be given the opportunity to determine the direction of his or her treatment, as appropriate.

The IPOC must contain the signature and title of the ASD network provider and the date signed. The beneficiary and/or the legal guardian(s) must sign the IPOC indicating they have been involved in the planning process and have been offered a copy of the IPOC.

If the beneficiary refuses to sign the IPOC, the clinician must document the refusal. If it is considered clinically inappropriate for the beneficiary to sign the IPOC, clinical justification must be documented on the IPOC

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

- The beneficiary's strengths, needs, abilities and preferences.
- The goals and objectives of treatment which must tie into the child's assessment and evaluation results.
- An outline to address the assessed needs of the beneficiary, 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 beneficiary.
- Specific treatment activities or interventions.
- Amount and type of parent/caregiver participation, as applicable to the beneficiary.
- 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 for ASD services. If the provider determines during treatment that additional services are required, these services should 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 IPOC. 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. A new electronic signature is necessary with every IPOC change for Medicaid

members. Beneficiaries are not required to have face-to-face contact with the ASD network provider in order for the provider to make the IPOC change of services or frequency.

Autism Spectrum Disorder Therapy Progress Summary Report

A progress summary spanning the previous authorized treatment period must be completed for all beneficiaries. 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).
- 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 beneficiary.
- Summary of the treatment plan for the upcoming treatment period, to tie into objectives and goals of the IPOC.
- 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.

Abbreviations

Abbreviations may be used in the CSN or IPOC. Service providers shall maintain a list of abbreviations and symbols used in the clinical documentation that leaves no doubt as to the meaning of the documentation. Providers must furnish the list and abbreviation key upon request of SCDHHS and/or its designee.

Error Correction

Medical records are legal documents. In the event that errors are made, adhere to the following guidelines:

For all paper record corrections:

- Draw one line through the error, and write “error”, “ER”, “mistaken entry”, or “ME” to the side of the error in parenthesis. Enter the correction, sign or initial, and date it.
- Errors cannot be totally marked through; the information in error must remain legible. No correction fluid may be used.

For all electronic health records, error correction must include date/time stamp and user ID.

Late Entries

Late entries may be necessary at times to handle omissions in the documentation.

Late entries should rarely be used, and then only used to correct a genuine error of omission or to add new information that was not discovered until a later date. Whenever late entries are made, adhere to the following:

Paper records:

- Identify the new entry as a “late entry”
- Enter the current date and time
- Identify or refer to the date and incident for which late entry is written
- If the late entry is used to document an omission, validate the source of additional information as much as possible

Electronic record late entries must include date/time stamp and user ID.

Same-Day Service Guidelines

Services must only be delivered when medically necessary considering all aspects of a child’s needs and other services a child is receiving to treat an ASD diagnosis or other physical, behavioral or mental health concerns. 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 beneficiary 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 beneficiary, then the provider may bill for the appropriate number of units using the table below.

The expectation is that a provider's direct beneficiary 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.