SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

AUTISM SPECTRUM DISORDER (ASD) SERVICES PROVIDER MANUAL

SEPTEMBER 1, 2025

South Carolina Department of Health and Human Services

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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

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COVERED POPULATIONS

ELIGIBILITY/SPECIAL POPULATIONS

Eligibility for Services

Services to treat Autism Spectrum Disorder (ASD) are provided to eligible Medicaid members age 0 through 20 years (up to the last day of the month of the beneficiary's 21st birthday) who have a diagnosis of ASD that meets criteria from the version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders at the time of the assessment, an Individuals with Disabilities Education Act (IDEA) designation that meets the South Carolina Department of Education standard for the disability category of ASD, or 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). Additionally, in accordance with the 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 Beneficiary's Eligibility

Participating Healthy Connections providers must access beneficiary 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.

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ELIGIBLE PROVIDERS

PROVIDER QUALIFICATIONS

To participate in the South Carolina 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 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 at: https://www.scdhhs.gov/providers/become-provider

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)

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

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.

All Medicaid-enrolled provider groups or schools must maintain a file substantiating each practitioner's qualifications and training. This must include employer verification of the ASD provider's license and/or board certification and work experience. 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 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.
- 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.

LIP(s) 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 SCMSA, 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. 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 per member:

- 30–40 hours per week = one case
- 10–25 hours per week = ½ case
- < 10 hours per week = ¼ case

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 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.

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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 beneficiary 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 beneficiary 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 beneficiary's condition.
   b. Must be administered in accordance with recognized and acceptable standards of medical and/or surgical discipline at the time the beneficiary receives the service.
   c. Must comply with standards of care and not for the beneficiary's convenience, experimental or cosmetic purposes.
   d. Medical necessity or any referral information must be documented in the beneficiary'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 autism spectrum disorder 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 8 of this manual. Medically necessary autism spectrum disorder services are covered as follows:

State Plan Services

Autism Spectrum Disorder 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 autism spectrum disorders (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 Early Periodic Screening Diagnosis and Treatment (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 beneficiary's home, in a clinic setting, or other settings as authorized in the applicable section of the SCDHHS provider manual.

Autism Spectrum Disorder (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. Autism Spectrum Disorder (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 South Carolina Department of Health and Human Services (SCDHHS).

Telehealth

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. 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 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 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 SCDHS 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 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, NP, CNM, PA, LIP, BCBA-D, BCBA, BCaBA, RBT
- Hospital (inpatient and outpatient)
- 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
- ABA providers, to include BCBA-D, BCBA, BCaBA

Covered Services

Specific services that are allowed to be delivered via Telehealth are documented in section 8 of this manual.

Office and OP 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 services are not reimbursable by Medicaid:

- Court appearances/testimony
- Supervision/staffing
- Mileage/driving time
- Completing/amending a Medicaid billing form.
- Any contact on behalf of a non-referred Medicaid member.
- Telephone contact related to office procedures or appointment time.
- Consultation for member 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

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.

EPSDT BENEFIT

Children under the age of twenty-one (21) are eligible for medically necessary services as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Federal law at 42 U.S.C.§1396d(r), §1905(r) of the Social Security Act (SSA)] 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," 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 at EPSDT | SCDHHS.

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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 Quality Improvement Organization (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 8 of this manual. Payment for services that exceed frequency limitations, will be made as determined as needed through the QIO. 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 a managed care organization (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 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 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 (POC) must be submitted to the QIO along with the SCDHHS ASD Prior Authorization Request Form.

For continued treatment, the most recent POC 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

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 individualized Plan of Care (POC) are completed, ABA providers may be authorized to deliver the services as outlined in Section 8.

For initial treatment requests, the original comprehensive diagnostic assessment and/or required physician documentation of a Medical Care Home based assessment and/or presumptive eligibility for ABA treatment services, as well as the Behavior Identification Assessment (BIA) and

individualized Plan of Care (POC) 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 member, reconsideration of services will be required. In such scenarios, the most recent POC 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.

For continued treatment, the most recent POC 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 POC 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 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).

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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 (4) years after the last payment was made for services rendered, to facilitate audits and reviews of the beneficiary'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 Current Procedural Terminology (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 present in the health record before the provider files claims for reimbursement. All services performed must be recorded in the

beneficiary'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. 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 Behavioral Identification Assessment for ABA services.
- Signed, titled and dated POC.
- Signed releases, consents, Member 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 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.
- Program 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.
- 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 from the date of hire.
- 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 may 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 the Health Insurance Portability and Accountability Act of 1996 (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 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 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 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 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

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 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 the 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).

- 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.

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) from the POC 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.

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

Individualized Plan of Care

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

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

The POC 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 POC indicating they have been involved in the planning process and have been offered a copy of the POC.

If the member refuses or is unable to sign the POC, the clinician must document this. If it is considered clinically inappropriate for the member to sign the POC, clinical justification must be documented on the POC.

For all members, the POC 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 relate to issues identified in the child's assessment and evaluation.
- 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.
- Amount and type of parent/caregiver participation, as applicable to the member.
- 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 POC 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 POC is not completed within this time frame, services rendered are not Medicaid reimbursable.

The POC 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 POC signature date stands as the date to be used for all subsequent reviews and reformulations.

A new POC 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 POC any time it is reformulated.

Services added or frequencies of services changed in an existing POC 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.

Autism Spectrum Disorder 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 POC 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 POC 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.

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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 the Healthcare Common Procedure Coding System (HCPCS) and the Current Procedural Terminology (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 Administrative and Billing Provider 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 POC 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.

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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 Services

Autism Spectrum Disorder Services

Applied Behavior Analysis (ABA) Therapy Services

Applied Behavior Analysis Assessment Services for POC Development

Assessments are to be completed by a BCBA-d, BCBA, or BCaBA. Assessments should include direct observation and measurement of member behavior in structured and unstructured situations, determination of baseline levels of adaptive and maladaptive behaviors and functional behavior analysis. Assessment services should only be offered and completed when the ABA provider is able to reasonably ensure they can provide the ABA treatment services deemed medically necessary by the BIA and POC. The following service descriptions are based on the Current Procedural Terminology (CPT) coding guidelines.

Behavior Identification Assessment (BIA) (97151)

Administered and completed by a BCBA-D, BCBA or BCaBA, face-to-face with patient and caregiver(s). 97151 does not require prior authorization. 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.

The 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 (97152)

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 (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.

**"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 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 POC 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 Behavior Identification Assessment and Behavior Identification Supporting Assessment must be completed one-on-one with the member, with the addition of collaterals as necessary.

Applied Behavior Analysis Treatment Services

Treatment services for ABA are provided via authorization once an POC 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 telehealth services are available for established patients 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 BCBA-D, BCBA or BCaBA.

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.

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.

Adaptive Behavior Treatment with Protocol Modification (97155)

Administered by a BCBA or BCaBA face-to-face 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 therapy hours, up to 64 units per month. Protocol Modification is a targeted treatment for the member and can not be used to document BACB required RBT supervision, without explicit documentation of one of the following:

1. The BCBA-D, BCBA, or BCaBA conducts 1:1 direct treatment with the patient to observe changes in behavior or **troubleshoot treatment protocols**; ***or***
2. 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 protoco**l.

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

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-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 guardian(s)/caregiver(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.

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 8 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.

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 POC 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 POC 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				
Assessment Services				
SERVICE NAME	**PROC CODE**	**PROVIDER/ SERVICE MODIFIER**	**UNIT FREQ**	**FREQUENCY LIMITS**
Behavior Identification Assessment	97151	BCBA-D BCBA BCaBA GT = Via interactive video/audio telecommunication	1 unit = 15 minutes	32 units annually, per member.
Behavior Identification Supporting Assessment	97152	BCBA-D BCBA BCaBA RBT* *Intended for RBT under direction of physician or other qualified health care professional, in-person with patient.*	1 unit = 15 minutes	21 units per day, per member.
Behavior Identification Supporting Assessment—2 or more Technicians	0362T	BCBA-D BCBA BCaBA RBT* *Must be billed by BCBA-D, BCBA, or BCaBA who is on site and directing treatment; service is in-person with patient.*	1 unit = 15 minutes	16 units per day, per member. *Claim is based on total time elapsed, not total time per each technician.*

ASD Treatment Services					
Adaptive Behavior Treatment by Protocol	97153		BCBA-D BCBA BCaBA RBT* Via interactive video/audio telecommunication	1 unit = 15 minutes	160 units per week, per member. *In any combination.*
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 weekly therapy hours, up to 64 units per month, per member. Must be used when BCBA-D, BCBA, or BCaBA: – Conducts 1:1 direct treatment with the patient to observe changes in behavior or **troubleshoot treatment protocols**; ***or*** – When 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 protoco**l.
Adaptive Behavior Treatment with Protocol	0373T		BCBA-D BCBA BCaBA RBT*	1 unit = 15 minutes	32 units per day, per member.

Modification—2 or more technicians			*Must be billed by BCBA-D, BCBA, or BCaBA who is on site and administering treatment; service is in-person with patient.*		*Claim is based on total time elapsed, not total time per each technician.*
Family Adaptive Behavior Treatment Guidance	97156		BCBA-D BCBA BCaBA GT = Via interactive video/audio telecommunication	1 unit = 15 minutes	96 units annually, up to 24 hours a year, per member.
Multi-Family Group Adaptive Behavioral Treatment guidance – *without patient*	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 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 Services

Developmental evaluation centers (DEC) 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), physician assistant (PA), a school psychologist or licensed psychoeducational specialist (LPES), licensed independent social worker (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 Developmental Evaluation Centers (DECs). DECs 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	**Neurodevelopmental Evaluation & Screening** • 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	00, GT	30-minute units, 12 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 Disabilities Pediatrician.		
T1023 TF	**Neurodevelopmental Evalation & Screening, Follow up** • 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 Pediatrician, General Pediatrician, Advance Practice Clinicians, Licensed Social Worker, RN or fellow under direct supervision of Board Certified Developmental/Behavioral or Neurodevelopmental Disability Pediatrician.	TF, GT	30-minute units, 48 units per year, per member.
T1024	**Psychological Developmental Eval. and Screening** • 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	**Psychological Developmental Eval. and Screening, Follow up** • 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	**Coordination of Care, Scheduled Team Conference** • 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	**Coordination of Care, Risk Adjustment Maintenance, Level 5** • 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

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 Autism Spectrum Disorder
- Medical-Care-Home Autism Assessment
- Presumptive Eligibility Determination Assessment

Comprehensive Diagnostic Assessment for Autism Spectrum Disorder

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:

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

2. *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.

3. *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.
   *****IMPORTANT* 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**.**

4. *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.

5. *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)

6. *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.*

7. *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).

8. *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:

1. Confirming medical necessity of ASD services for a member with a pre-existing diagnosis or designation of Autism Spectrum Disorder as outlined below.

2. 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 Neccessity 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 SCDOE and SCBHDD-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 Comprehensive Diagnostic Assessment (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 Autism Spectrum Disorder

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:

1. *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. **

2. *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.

3. *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)

4. *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)

5. *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 **

6. *A diagnosis from the current edition of the DSM*, including severity levels, indicated by completion of the DSM checklist.

7. 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.

8. Completion of the *Autism Diagnostic Tool for Physician Use in the Medical Care Home* (See FORMS section).

9. *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 applied behavior analysis (ABA) services until their 6th birthday while awaiting a comprehensive diagnostic assessment (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 Developmental Evaluation Center (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)