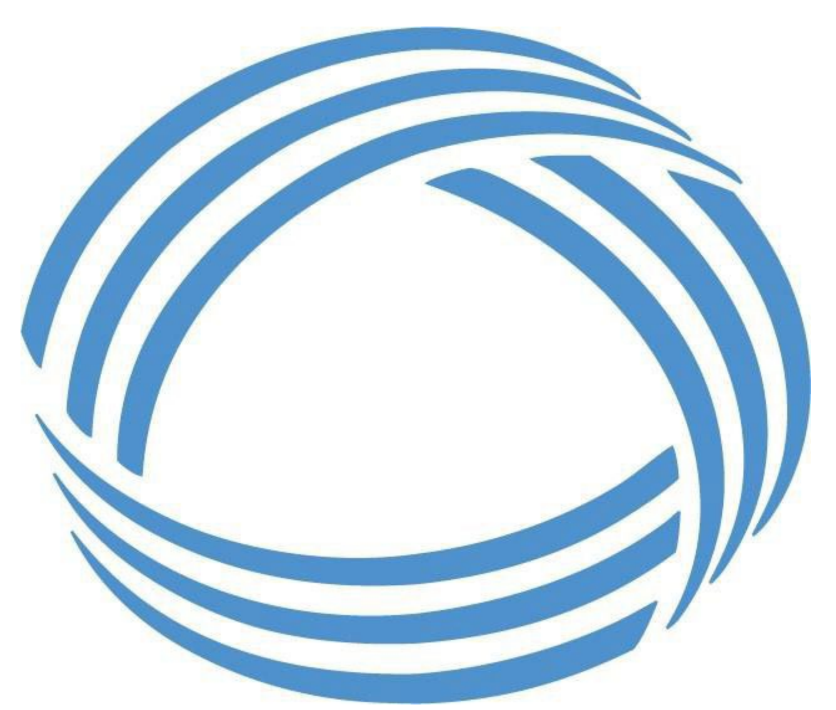
PART II

POLICIES AND PROCEDURES

for

AUTISM SPECTRUM DISORDER (ASD) SERVICES



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

Revised: January 1, 2023

Policy Revisions Record

Part II Policies and Procedures Manual for Autism Spectrum Disorder (ASD) Services

Revision Date	Section	Revision Description	Revision Type	Citation
			A = Added D = Deleted M = Modified	(Revision required by Regulation, Legislation, etc.)
01/01/2021	All	Date Change	M	Policy
01/01/2021	Page 7	IDEA Act reference	M	Policy
2/5/2021	Appendix A	Updated rate for 97155 U3 U7	M	
02/15/2021	Table of Contents	Missing sections and appendix	M	
02/15/2021	Appendix B Autism Attestation	Deleted	D	
02/15/2021	Appendix C Medicaid Non-Emergency Transportation	Renamed to Appendix B	M	
02/15/2021	Appendix D Georgia Families	Renamed to Appendix C	M	
02/15/2021	Appendix E Georgia Families 360°SM Program	Renamed to Appendix D	M	
02/15/2021	Appendix F 2019 Autism Code Crosswalk	Renamed to Appendix E	M	
02/15/2021	All	Date Change	M	
02/16/2021	601.4 Attestation	Removed	D	
2/18/2021	Appendix B	Updated Logisticare's name	M	
3/1/2021	Appendix A	Removed additional code combo list and all references to it	M	

3/16/2021	601.1.2 Facility Enrollment	Removed the word “facility”	M	
3/16/2021	601.3 Direct Supervision	Removed supervisee limits	M	
4/15/2021	Appendix A	Removed Master's Level Behavior Analyst from Level 4 provider	M	
5/17/2021	Appendix C	Removed reference to Wellcare	M	Peach State merger
5/17/2021	Appendix A and C	Updated DXC to Gainwell	M	
5/17/2021	701.1	Updated General Eligibility	M	Alliant Health recommendation
5/17/2021	801	Removed 3 year requirement	M	Alliant Health recommendation
5/17/2021	801	Updated reevaluation guidelines	M	Alliant Health recommendation
9/28/2021	Appendix G	“Change Request” guidance added	A	Alliant Health recommendation
10/14/2021	903 Assessment and Service Descriptions	Removed BCaBA and RBT from Protocol Modification services because only U1-U3 clinicians may bill with these codes.	M	
1/1/2022	Appendix G	Updated guidelines related to members changing providers and end-dating current PA	M	Alliant Health recommendation
1/1/2022	801 Prior Approval for ABS	Added Clinician and Caregiver assessment tools table	A	Alliant Health recommendation
4/1/2022	G-1 Autism Therapy Request Guidelines and Restrictions	Revised “All requests may be submitted with a procedure start date up to 30 days in the future” to “All requests may be submitted with a procedure start date up to 60 days in the future”	M	Policy
4/1/2022	701.1	Revised first sentence in first paragraph related to diagnosis	M	
7/1/2022	602.5	Updated IDEA website link	M	
10/1/2022	Appendix F	Condensed Coversheet to 3 pages	M	
1/1/2023	Appendix F	Added info related to: graph, baseline, and school-based ABA	A	

1/1/2023	Appendix G: Reconsideration Request Guidelines	Moved the statement, "Only one (1) reconsideration request submission per PA request following a peer denial can be submitted" from 4th bullet to the 1st bullet and placed it in bold print.	M	
1/1/2023	Appendix G: End-Date PA	Revised instructions on end-dating PAs	M	
1/1/2023	Appendix G: Retro PAs	Added Katie Beckett reference	A	
1/1/2023	Appendix A	Added 0362T and 0373T to MUE chart	M	
1/1/2023	Appendix F	Added "(Example) Supervision: Wed 2-3pm/ Home, Clinic/BCBA, client" below Direct Service	A	
1/1/23	701.1 General Eligibility	Revised paragraph following bullets	M	

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PART II - CHAPTER 600: SPECIAL CONDITIONS OF PARTICIPATION

601 Conditions

In addition to the conditions for participation outlined in Part I, Autism Spectrum Disorder (ASD) Providers must:

601.1 Credentials

Hold either a current and valid license to practice Medicine in Georgia, hold a current and valid license as a Psychologist as required under Georgia Code Chapter 39 as amended, or hold a current and valid Applied Behavior Analysis (ABA) Certification.

601.1.1 Applied Behavior Analysis (ABA) Certification

In addition to licensed Medicaid enrolled Physicians and Psychologists, Georgia Medicaid will enroll Board Certified Behavioral Analysts (BCBAs) as Qualified Health Care Professionals (QHCPs) to provide ASD treatment services. The BCBA must have a graduate-level certification in behavior analysis. Providers who are certified at the BCBA level are independent practitioners who provide behavior-analytic services. In addition, BCBAs supervise the work of Board Certified Assistant Behavior Analysts (BCaBAs) and Registered Behavior Technicians (RBTs) who implement behavior-analytic interventions.

The following providers are authorized to directly deliver ASD services:

- **Licensed Physician** (with or without BCBA certification):
  - May be the enrolled QHCP.
  - May supervise the work of BCaBAs and RBTs who implement behavior-analytic interventions.
- **Licensed Psychologist** (with or without BCBA certification):
  - May be the enrolled QHCP.
  - May supervise the work of BCaBAs and RBTs who implement behavior-analytic interventions.
- **Board Certified Behavior Analyst- Doctoral Level** (BCBA-D):
  - A doctoral level independent practitioner qualified to provide behavior-analytic services/ direct services.
  - May be the enrolled QHCP.
  - May supervise BCaBAs, RBTs, and others who implement behavior-analytic interventions
- **Board Certified Behavior Analyst** (BCBA):
  - A masters/graduate level independent practitioner qualified to provide behavior analytic services/ direct services.
  - May be the enrolled QHCP.
  - May supervise the work of BCaBAs and RBTs who implement behavior-analytic interventions.
- **Board Certified Assistant Behavior Analyst** (BCaBA):
  - Bachelor's level practitioner

- May not be the enrolled QHCP
  - Must be supervised by a physician, psychologist, or BCBA/BCBA-D
  - May supervise the work of RBTs.
- **Registered Behavior Technician** (RBT):
  - Paraprofessional who implements the service plan under supervision of a BCBA/ BCBA-D or BCaBA
  - May not be the enrolled QHCP.
  - Must be supervised by a BCBA/BCBA-D or BCaBA

601.1.2 Enrollment

Individual practitioners (physicians, psychologists, BCBAs-D, BCBAs) working for a facility will need to enroll as a provider associated with the facility they are providing services through. BCaBAs and RBTs are not enrolled directly by the Division as providers because they are not independent practitioners. Level 4 and 5 practitioners work under the supervision of higher level practitioners. Facilities are required to bill at the appropriate practitioner level and service code for service rendered.

601.2 Standard Billing Practice

The provider agrees to bill the Division the lowest price regularly and routinely offered to any segment of the general public for the same service or item on the same date(s) of service or the lowest price charged to other third-party payers for the procedure code most closely reflecting the service rendered.

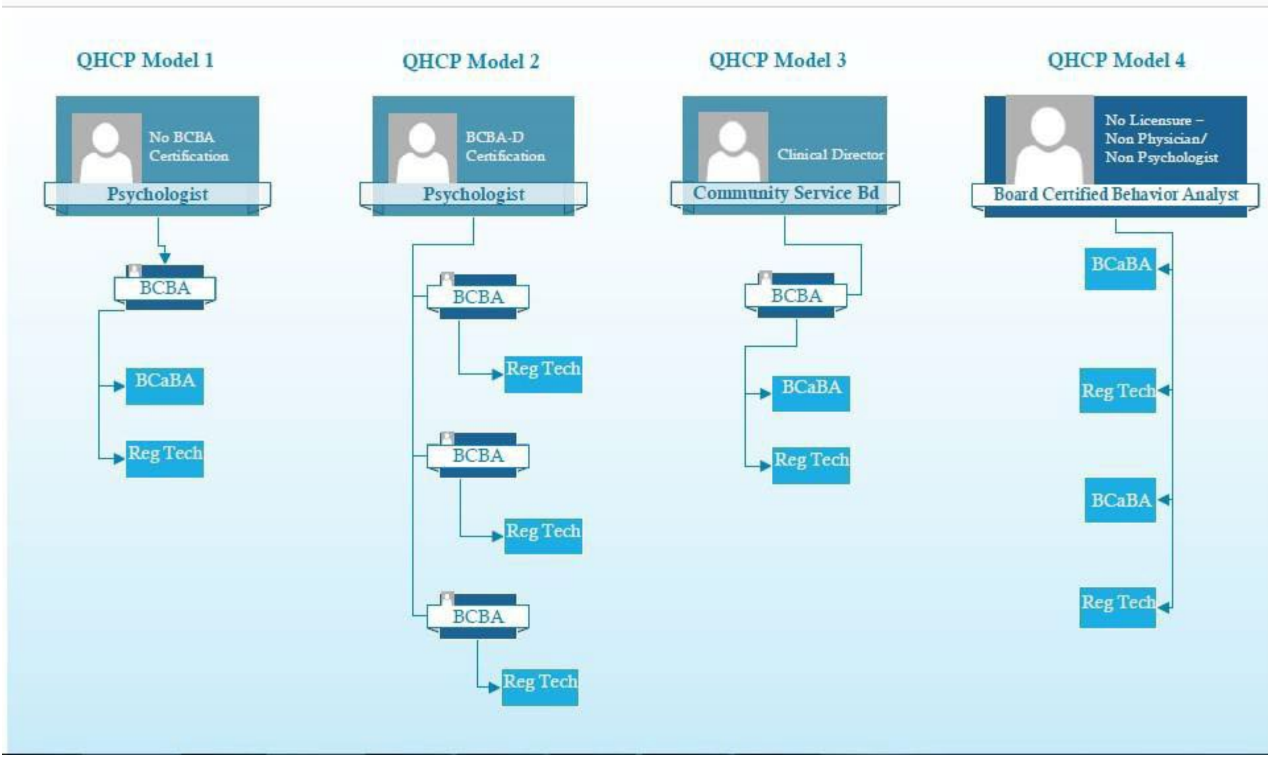
601.3 Direct Supervision

Agree to bill the Division for only those services rendered by the provider or by a Qualified Health Professional under the provider direct supervision. Please see O.C.G.A. Title 43, Chapter 11 for statutes regarding direct supervision. Under no circumstances may a provider bill for services rendered by another practitioner who is enrolled or eligible to enroll as a provider of services in the Medical Assistance program.

“Supervision" means the direct clinical review, for the purpose of training or teaching, by a physician, psychiatrist, BCBA-D, or BCBA. The purpose of supervision is to promote the development of the practitioner's clinical skills. Supervision may include, without being limited to, the review of case presentations, audiotapes, videotapes, and direct observation of the practitioner's clinical skills. Supervision does not require the supervisor to be present at the work site with the supervisee. Both supervisors and supervisees are required to maintain a contemporaneous record of the date, duration, type, and brief summary of the pertinent activity for each supervision session to be submitted for auditing upon request. If there are any discrepancies the associated claims are subject to recoupment.

The Qualified Health Care Provider (QHCP) must supervise non-enrolled practitioners who are involved in the delivery of Adaptive Behavioral Services (ABS) to Medicaid members with ASD and for which such services are being claimed to Medicaid under the enrolled provider identification number of the QHCP and/or facility. However, such supervision must be performed in accordance with the supervision guidelines of the Behavior Analyst Certification Board and this policy manual.

There are several potential models for enrollment and supervision. The exhibit below demonstrates example supervision models. The examples are not intended to reflect the full scope of all potential models.



Delegation by QHCP:

- The QHCP is responsible for the delegated work performed by any supervisees.
- The QHCP shall not delegate professional responsibilities to a person who is not qualified to provide such services. Physicians, Psychologists, BCBA-Ds, and BCBAs may delegate to the supervisee, with the appropriate level of supervision, only those responsibilities within the scope of practice.
- The QHCP must have completed education and training, including training on supervision rules and professional ethics as outlined by applicable administrative practice acts, standards of practice, or certification guidelines, to perform the delegated functions.
- The QHCP is responsible for determining the competency of the supervisee and will not assign or allow the supervisee to undertake tasks beyond the scope of the supervisee's training and/or competency. The QHCP is also responsible for providing the supervisee with specific instructions regarding the limits of the supervisee's role.
- The supervisee may be an employee or independent contractor of the QHCP. If not directly employed, the contract with the QHCP must maintain compliance with the Department's policies in the delivery of ABS, including Medicaid enrollment requirements.

602. Standard Billing Practices

In addition to the conditions for participation outlined in Part I, Autism Spectrum Disorder Providers must bill according to the following practices:

602.1 Provider Changes

Agree to immediately notify the Division's Provider Enrollment Unit via the GAMMIS web portal should any change in enrollment status occur such as: new address or telephone number; additional practice or office locations; change in payee; close of any individual practice; dissolution of a group practice causing any change in the Division's records; change in staffing; and voluntary termination from the Medical Assistance program. Each notice of change must include the date on which the change is to become effective.

602.2 Rendered Services

Agree to bill the Division the procedure code(s) which best describes the service rendered and not to bill under separate procedure codes for services which are included under a single procedure code.

602.3 Record Documentation

It is the responsibility of all Georgia DCH enrolled providers to ensure the health records of Medicaid members are documented accurately and maintained in compliance with both state, federal and national laws. Providers are responsible for being aware of record keeping requirements as outlined by the Centers for Medicare & Medicaid Services (CMS), Georgia DCH, other program affiliated associations and Health Insurance Portability and Accountability Act (HIPAA) guidelines. The Georgia DCH recommends the following record keeping guidelines. These recommendations should be considered ***basic*** - a minimum standard for each provider's practice. It is not inclusive of all record keeping requirements and providers will be responsible for any additional documentation requested in the event of audits. Records should include:

- A complete medical file on each patient containing sufficient information to validate the diagnosis and to establish the basis upon which treatment is given.

- A care plan that includes clear and specific coordination with all providers involved in the treatment of the individual. It should include (but not be limited to) individualized expectations, prescribed services, service frequency, scope and duration and goals to be achieved.

- Progress notes that are legible, detailed, complete, signed and dated.

- All documentation requiring signatures must be legible, original and belong to the person creating the signature. If illegible, the name should be printed as well as signed. All signatures must be dated the actual date signed. Rubber stamp signatures are not acceptable. Electronic signatures are acceptable in certain circumstances. See Part I

Policies and Procedures for Medicaid/Peachcare for Kids, Section 106, General Conditions of Participation.

- If corrections are needed, they should be made by striking one line through the error, writing the correction, and including the initials of the person making the correction along with the date the correction is made. Whiteout **cannot** be used for corrections.

- Records should be documented in 'real time' and should **not** be back-dated.

- At a minimum, member records should include but not be limited to the following:

1. Individual's name and/or other information related to their identification (SS#, Medicaid ID, etc…)
2. Date and time of admission
3. Admitting Diagnosis
4. Verified Diagnosis
5. The name, address, and telephone number of the responsible party to contact in an Emergency
6. Appropriate authorizations and consents for medical procedures
7. Medical necessity of the service being provided
8. Results of testing and/or assessments
9. Records or reports from previous or current providers including previous assessments
10. Documented correlation between assessed need and care plan
11. Documentation of treatment that supports billing
12. Financial and insurance information
13. Pertinent medical information
14. Physicians' progress notes
15. Nurses' notes
16. Practitioner and case management notes
17. Clear evidence that the services billed are the services provided
18. Treatment and medication orders
19. Date and time of discharge or death
20. Condition on discharge

602.4 Record Maintenance

Maintain copies of submitted claims, clinical documentation, and all corresponding supporting materials for a minimum of five (5) years from the date(s) the service(s) is provided.

602.5 Locum Tenens

Locum Tenens is a long-standing and widespread practice for a provider to retain a substitute provider to take over his/her professional practice when the regular provider is absent for reasons such as illness, pregnancy, vacation, or continuing provider education. The regular provider will

be able to bill and receive payment for the substitute provider as though he or she performed the services himself/herself. The substitute provider is generally called 'locum tenens' provider. A member's regular provider may submit a claim and receive payment for services (including emergency visits and related services) of a locum tenens provider who is not an employee of the regular provider and whose services for members of the regular provider are not restricted to the regular provider's offices, if:

- The regular provider is unavailable to provide the visit services.
- The Medicaid Member has arranged or seeks to receive the services from the regular provider.
- The regular provider pays the locum tenens for his or her services on a per diem or similar fee-for-time basis.
- The substitute provider does not provide the visit services to Medicaid members for a period of time not to exceed sixty continuous days.
- The covering provider must be an enrolled Medicaid provider.
- The locum tenens should have a valid Medicaid number in the State of Georgia.
- Reimbursements will be for services which the regular provider (or group) is entitled to submit.
- A provider or other person who falsely certifies any of the above requirements may be subject to possible civil and criminal penalties for fraud.
- The common practice of one provider covering for another will not be construed as a violation of this section. The service furnished by the covering provider is an informal reciprocal arrangement. Providers should be aware that the services furnished by the substitute provider should be identified in the Member's medical record held by the regular provider, which is available for inspection.

NOTE: Autism Spectrum Disorder Services do not include educational services otherwise available through a program funded under 20 USC Chapter 3, section 1400 of the Individuals with Disabilities Education Act (IDEA). Congress reauthorized the IDEA in 2004 and most recently amended the IDEA through Public Law 114-95, The Every Student Succeeds Act, in December 2015. Information about the IDEA Act is found on the U.S. Department of Education site at: Individuals with Disabilities Education Act (IDEA)

PART II - CHAPTER 700: SPECIAL ELIGIBILITY CONDITIONS

701 Special Eligibility Conditions

Services to treat Autism Spectrum Disorders (ASD), as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, include assessment and treatment provided to Medicaid beneficiaries in accordance with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit and according to medical necessity. Pursuant to 42 CFR 440.130(c), services must be recommended by a licensed physician or other licensed practitioner of the healing arts acting within their scope of practice under state law to prevent the progression of ASD, prolong life, and promote the physical and mental health of the individual.

701.1 General Eligibility

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- Autism Spectrum Services are for individuals under the age of 21.
- Children must be able to participate in sessions.
- The member must exhibit behaviors that present as clinically significant health or safety risks to self or others or are behaviors that are significantly interfering with basic selfcare, communication, or social skills.
- Members/Caregivers must be able to participate in ABS therapy and have the ability to implement ABS techniques in the home environment as instructed by their behavior analyst. If they are unwilling/unable to implement therapeutic interventions in the home, consideration will be given to other modalities of treatment as ABS needs to be consistently applied in all environments to be successful. Use of ABS in no way precludes other treatment inventions with ABS such as PT, OT, and other forms of behavioral therapy, family therapy, and/or medication management.

The diagnosis must be made by a practitioner enabled by the OCGA practice acts to diagnose behavioral health/intellectual/developmental conditions. Diagnosis should be made and confirmed using acceptable evidence-based tools as listed in **Section 801** and **must** include a **minimum** of 1 primary clinician tool **<u>and</u>** 1 caregiver tool.

The following must be ruled out as causal reasons for behavior:

- Primary hearing deficits
- Primary speech disorder
- Heavy metal poisoning

The following ICD-10 CM Diagnosis Codes are required for reimbursement of treatment.

ICD 10 CM Code	Description
F84.0	Autistic Disorder
F84.2	Rett's Syndrome
F84.3	Other childhood disintegrative disorders
F84.5	Asperger's Syndrome
F84.8	Other pervasive developmental disorders
F84.9	Pervasive developmental disorder, unspecified

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801. Prior Approval for Adaptive Behavior Services (ABS)

Prior Authorization (PA) is required for all Medicaid-covered ABS. Services without a PA will not be covered. Services are authorized in two parts, 1) Behavioral Assessment, and 2) Treatment Services. A Behavioral Assessment is the administration of an industry-standard assessment tool for skill acquisition and/or behavior reduction and is required to substantiate future treatment services. Treatment Services require a Plan of Care (POC) that incorporates the results of the behavioral assessment, individualized goals based on the results, transition and discharge plans, and information on coordination with other providers, as appropriate. ABS can be requested in 3-month increments (Behavioral Assessment) and 6-month increments (Treatment Services).

All ABS PAs must be requested by the enrolled QHCP.

A documented diagnosis of ASD must be established by a licensed physician or psychologist, or other licensed professional as designated by the Medical Composite Board prior to completing a PA for Behavioral Assessment or Treatment Services. As stated in 701, the diagnostic evaluation must use valid and reliable evaluation tools that conform to industry standards and include direct observation, parent/caregiver interviews, and standardized tools for the diagnosis of autism.

The diagnostic evaluation should be comprehensive with multiple informants, when possible, and cover multiple domains. The results of the evaluation should be submitted in a report format that contains a summary of each individual evaluation instrument, the developmental history, and presenting concerns. Test forms alone are not acceptable.

The evaluation should meet the following:

- Minimum of two (2) assessment tools (1 clinician observational assessment, 1 caregiver assessment)
- Summary of each individual assessment.
- Include the date it was completed and include the tests administered with scores.
- Include the evaluators name and credentials.

In general, two measures are required as multi-modal, multi-informant assessments are empirically supported. The following tools were selected due to meeting the following criteria:

- Standardized assessment tools specifically utilized to assess ASD or the specific core characteristics present in individuals with ASD
- Robust empirical support for the individual’s age
- Includes diagnostic validity and reliability for this purpose

Primary Clinician Tool	Other tools needed:
ADOS2 (Autism Diagnostic Observation Schedule) 12 months through adulthood	Parent input via formal tool (screener, rating scale, or clinical interview)
GARS-3 (by clinician) (Gilliam Autism Rating Scale) 3 - 22 years	Parent input via formal tool (screener, rating scale, or clinical interview)
CARS2 ST/HF (Childhood Autism Rating Scale) 2 years and up	Parent input via formal tool (screener, rating scale, or clinical interview)
STAT (Screening Tool for Autism in Toddlers and Young Children) 24 – 35 months	Parent input via formal tool (screener, rating scale, or clinical interview)
CSBS (Communication and Symbolic Behavior Scales) 6-24 months	Parent input via formal tool (screener, rating scale, or clinical interview)
TELE-ASD-PEDS Children under 3 years	Parent input via formal tool (screener, rating scale, or clinical interview)
NODA (Naturalistic Observational Diagnostic Assessment) 18 months – 6 years	Parent input via formal tool (screener, rating scale, or clinical interview)
DISCO (Diagnostic Interview for Social and Communication Disorders) any age	Parent input via formal tool (screener, rating scale, or clinical interview) – the DISCO can be used as a parent interview and/or clinical observation tool
Rapid Interactive Screening Test for Autism in Toddlers (RITA-T) 18 – 36 months	Parent input via formal tool (screener, rating scale, or clinical interview)
Autism Detection in Early Childhood (ADEC) children under 3 years	Parent input via formal tool (screener, rating scale, or clinical interview)
Caregiver Tool	
Accepted ASD specific Caregiver tools:	
ADI-R (Autism Diagnostic Interview) 2 years and up	Primary Clinician tool
DISCO (Diagnostic Interview for Social and Communication Disorders) any age	Primary Clinician tool
CARS QPC (Childhood Autism Rating Scale – Parent Questionnaire) 2 years and up	Primary Clinician tool (other than CARS)
GARS-3 (Gilliam Autism Rating Scale) 3 – 22 years	Primary Clinician tool (other than GARS)

SCQ (Social Communication Questionnaire) 4 years and up	Primary Clinician tool
MCHAT (Modified Checklist for Autism in Toddlers) 16-30 months	Primary Clinician tool
SRS-2 (Social Responsiveness Scale) 2.5 and up	Primary Clinician tool
ASRS (Autism Spectrum Rating Scale) 2 – 18 years	Primary Clinician tool
Autism Behavior Checklist (ABC) 3 years and older	Primary Clinician tool
Toddler Autism Symptom Inventory (TASI) 12-36 months	Primary Clinician tool
<u>Accepted Non-ASD specific Caregiver tools:</u>	**These can be used as a parent/caregiver assessment**
BASC (Behavior Assessment System for Children) 2 – 21 years, 11 months	Primary Clinician tool
PDD-BI (PDD-Behavior Inventory) 18 months – 18 years, 5 months	Primary Clinician tool
PEDS:DM (Parents' Evaluation of Developmental Status) birth – 7 years, 11 months	Primary Clinician tool
ASQ-3 (Ages and Stages Questionnaire) 1 - 66 months	Primary Clinician tool
ASQ:SE2 (Ages and Stages Questionnaire: Social Emotional) 6 – 60 months	Primary Clinician tool
CBRS (Conners Behavior Rating Scale) 6 – 18 years	Primary Clinician tool
CDI (Child Development Inventory) 0-6 years	Primary Clinician tool
CSBS DP Infant-Toddler Checklist 6-24 months	Primary Clinician tool
Other tools that may be used in autism assessments, but do not meet criteria:	
Vineland-3 (VABS) birth - 90+ years	Primary Clinician tool and accepted Caregiver tool
ABAS-3 birth – 89 years	Primary Clinician tool and accepted Caregiver tool

A diagnostic re-evaluation to re-confirm diagnosis may be required if any of the following is indicated in the request.

- Provisional diagnosis of Autism Spectrum Disorders (as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders).
- No formal neuropsychological evaluation was completed/conducted.
- More than 5 years from initial diagnosis and no evidence of ongoing assessment and treatment.
- The re-evaluation must include, at a minimum, 1 clinician observational assessment.

School psychoeducational assessments are not acceptable for diagnostic evaluations.

A PA to perform an initial or follow-up Behavioral Assessment is required to be completed separately from the PA for Treatment Services.

For the purposes of authorizing ABS, Medicaid will accept for submission, the findings from a diagnostic evaluation that was not approved/covered by Medicaid.

801.1 Behavioral Assessment

A PA is required for the Behavioral Assessment. The Behavioral Assessment is separate from the initial diagnostic evaluation and is used to identify areas of strength and weakness and to develop specific goals for treatment for both the individual and the caregivers involved. The Behavioral Assessment for skill acquisition may include Verbal Behavior Milestones and Assessments Placement Program (VB-MAPP), Assessment of Basic Language and Learning Skills – Revised (ABLLS-R), Assessment of Functional Living Skills (AFLS), Promoting the Emergence of Advanced Knowledge Generalization (PEAK), or Skills assessment. Behavioral Assessments for maladaptive behavior may include functional behavioral assessments, traditional functional analyses, or Interview-Informed, Synthesized Contingency Analysis (IISCAs). The results of the Behavioral Assessment should be summarized and used to develop any future interventions in the form of a POC. The POC is a required component of any future requests for Treatment Services

The documentation that must be submitted to substantiate the request for an assessment PA should include:

- Diagnostic evaluation
- Letter of Medical Necessity
- Individualized Family Service Plan (if applicable).
- Individual Education Plan (if applicable).
- Previous Hospitalization or out-of-home placement documents (if applicable).
- Medicaid Cover Page (Appendix G)
- Any other clinical documentation needed to support the plan of care as supported by best practices.

801.2 Treatment Services

A PA is required for ABS Treatment Services. Treatment Services are dictated by the results of a recent Behavioral Assessment and resulting POC. The Behavioral Assessment must have been

conducted/dated no more than two (2) months prior to the Treatment Services PA request.

The documentation that must be submitted to substantiate the request for a treatment PA should include:

- Diagnostic evaluation
- Letter of Medical Necessity
- Descriptive results of behavioral assessment as defined in 801.1 above.
- Proposed Plan of Care (POC) –see section 801.22 below-
- Updated data collected during previous treatment authorizations (if not initial request)
- Individualized Family Service Plan (if applicable).
- Individual Education Plan (if applicable).
- Previous Hospitalization or out-of-home placement documents (if applicable).
- Progress Notes (if applicable).
- Medicaid Cover Page (Appendix F)
- Any other clinical documentation needed to support the plan of care as supported by best practices.

Typically, Treatment Services can range from 10 - 30 hours per week but can be more, or less, if medically necessary. Treatment should be commensurate with the member's skill deficit or behavioral excesses as identified in the behavioral assessment. All Treatment Services require active parent/ caregiver participation and involvement to increase the potential for behavior improvement/ changes in those behaviors identified as causing limitations or deficits in functional skills.

PA requests for follow up services (following the initial treatment PA) must include 1) a summary of previous goals and progress, 2) the results of a recent Behavioral Assessment (within 2 months), and 3) individualized goals for the individual and caregivers as described in section 4 (Service Authorization and Dosage) of the practice guidelines for treatment of ASD developed by the Behavior Analyst Certification Board. PAs for re-assessment can be submitted prior to the current treatment PA expiration date.

801.2.2 Plan of Care (POC)

The POC should include a clear connection between the results of the behavioral assessment to the specific goals developed for the individual. The goals should highlight areas identified as in need of remediation, with special focus on pivotal, functional skills related to the core deficits of ASD. The goals must include baseline data, measurement, and mastery criteria aim to address the core deficits of ASD as described in the practice guidelines for treatment of ASD set forth by the Behavior Analyst Certification Board (BACB).

Treatment for Autism Spectrum Disorder (ASD) must**:**

- Demonstrate that ABS are not custodial or maintenance-oriented in nature;
- Include coordination across all providers, supports, and resources;
- Identify parent, guardian, and/or caregiver involvement in prioritizing target behaviors and training in behavioral techniques in order to provide additional supportive interventions;
- Include criteria and specific behavioral goals and interventions for lesser intensity of care and discharge;

- Provide evidence that applicable community resources have been identified and engaged;
- Provide evidence/support for a reasonable expectation that the member can benefit from the services proposed.

PART II - CHAPTER 900: SCOPE OF SERVICES

901. General

Federal regulations allow the state agency to place appropriate limits on medical necessity and utilization control. The Division has developed reimbursement limitations to ensure appropriate utilization of funds. These limitations consist of (a) prior approval requirements described in Chapter 800, and (b) service limitations described in Section 903.

902. Coding of Claims

Coding of both diagnoses and procedures is required for all claims. Codes deleted from previous editions of the ICD are not accepted by the Division. The ICD-10 CM coding scheme consists of three volumes. Volumes I and II are needed by physicians. ICD-10 codes range that begin with V81.2XXA - Y36.0105 are not accepted by the Division. The remaining special category of codes that begin with “V” or “Z” are acceptable only if the “V” code or “Z” code (ICD-10) describes the primary diagnosis. The provider must select the diagnosis codes that most closely describe the diagnosis of the member. In coding a diagnosis on a claim, the code must be placed on the claim form using the identical format. Coding must be to the highest level.

902.1 General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) Provider

The Patient Protection and Affordable Care Act (PPACA) requires physicians and other eligible practitioners who order, prescribe, and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. CMS expanded the claim editing requirements in § 1833(q) of the Social Security Act and providers definitions in § 1861-r and § 1842(b) (18) C to align with the PPACA. To comply with the PPACA, claims for services that are ordered, prescribed, or referred must indicate the ordering, prescribing, or referring (OPR) practitioner. The Division will utilize an enrolled OPR provider identification number to verify Georgia Medicaid enrollment. Any OPR physician, or other eligible practitioner, who are not enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers. The National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the rendering provider. If the NPI of the OPR Provider denoted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, the claim will be denied.

Effective 1 April 2014, the Division will check claims for the NPI of all ordering, prescribing, and referring providers in accordance with the OPR regulation. This edit will be informational until 1 June 2014. Effective 1 June 2014, inclusion of the ordering, prescribing, and referring information will become mandatory. Claims that do not contain the required information will be denied.

- For CMS-1500 claim form: Enter qualifiers to indicate if the claim has an ordering, prescribing, or referring provider to the left of the dotted line in box 17 (Ordering = DK; Referring = DN or Supervising = DQ).
- For claims entered via the web: Claims headers were updated to accept ordering or referring Provider ID and name for Dental and Institutional claims and the referring provider's name for Professional claims. The claim detail was updated to accept an ordering or referring provider ID and name. Utilize the "ordering" provider field for claims that require a prescribing physician.
- For claims transmitted via EDI: The 837 D, I, and P companion guides were updated to specifically point out the provider loops that capture the rendering, ordering, prescribing, referring and service facility provider information that is now used to transmit OPR information. The following resources are available for more information:
  - Access the Division's DCH-I newsletter and FAQs at: http://dch.georgia.gov/publications
  - Search to see if a provider is enrolled at: https://www.mmis.georgia.gov/portal/default.aspx
  - Choose the 'Provider Enrollment/Provider Contract Status' option.
  - Enter Provider ID or NPI and provider's last name.
  - Access a provider listing at: https://www.mmis.georgia.gov/portal/default.aspx.

903 Assessment and Service Descriptions

Assessment Descriptions

Service	Assessment Description	Authorized Provider Type
Behavior Identification Assessment	Behavior Identification Assessment, is delivered by a Physician or other Authorized Provider Type, face-to-face with the member and caregiver(s). It includes administration of standardized and non-standardized tests, detailed behavioral history, member observation and caregiver interviews, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of a report for a plan of care.	Physician Psychologist BCBA-D BCBA
Observational Behavioral Follow-up Assessment	Observational Behavioral Follow-up Assessment is designed by the practitioner to identify and evaluate factors that many impede the expression of adaptive behaviors. The assessment utilizes structured observation and/or standardized and non-standardized tests to determine the levels of adaptive behavior. It enables the practitioner to evaluate a member's social behavior to determine if the member has a particular set of social skills, as well as the contexts in which social responses are either likely or unlikely to occur. Practitioners may assess cooperation, motivation, visual understanding, receptive and expressive language, imitation, request, labeling, play and leisure, and social interactions. Observational Behavioral Follow-up Assessment includes Physician or other Authorized Provider Type direction, with interpretation and report, administered by one of the Authorized Provider Types. The first thirty (30) minutes of the Authorized Provider Type's time, face-to-face with the member. Additional (30) minute increments are authorized in accordance with medical necessity.	Physician Psychologist BCBA-D BCBA BCaBA RBT
Exposure Behavioral Follow-up Assessment	Exposure Behavioral Follow-up Assessment is designed by the practitioner to manipulate or stage environmental or social contexts in order to examine triggers, events, cues, responses, and consequences associated with maladaptive destructive behavior(s). This service requires the practitioner to provide on-site direction to technicians providing direct service. Exposure behavioral follow-up assessment often requires the use of protective gear and/or padded room to avoid injuries to member and others. Exposure Behavioral Follow-up assessment, includes Physicians or other Authorized Provider Type, direction with interpretation and report, administered by Physician or Authorized Provider Type with the assistance of one or more Authorized Provider Type; first thirty (30) minutes of the Authorized Provider Type's, face-to-face with the member. Additional (30) minute increments are authorized in accordance with medical necessity.	Physician Psychologist BCBA-D BCBA BCaBA RBT

Service Descriptions

Code	Service Description	Authorized Provider Type
Adaptive Behavior Treatment	Adaptive Behavior Treatment addresses the member's specific target problems and treatment goals as defined in assessments. Adaptive behavior treatment is based on principles including analysis and alternation of contextual events and motivating factors, stimulus-consequence strategies and replacement behavior, and monitoring of outcome metrics. Goals of adaptive behavior treatment may include reduction of repetitive and aberrant behavior, and improved communication and social functioning. Adaptive behavior skills tasks are often broken down into small, measurable units, and each skill is practiced repeatedly until the member masters it. Adaptive Behavior Treatment by protocol, administered by Authorized Provider Type, face-to-face with one member; first thirty (30) minutes of the Authorized Provider Type's time. Additional (30) minute increments are authorized in accordance with medical necessity. Adaptive Behavior Treatment can be provided on in an individual, group, family or multi-family setting.	Physician Psychologist BCBA-D BCBA BCaBA RBT
Adaptive Behavior Treatment with Protocol Modification	Adaptive Behavior Treatment with Protocol Modification includes skills training delivered to a member who has poor emotional responses and/or deviation in rigid routines. The practitioner introduces small, incremental changes to the members expected routine along one or more stimulus areas. More intrusive changes in routines are faded into preferred daily activities until the member appropriately tolerates typical variation in daily activities without poor emotional responses. The service may include demonstration of new or modified protocol for a technician, guardian, and/or caregiver. The practitioner modifies the past protocol targeted for desired results to incorporate changes in the context and environment. Adaptive Behavior Treatment with protocol modification administered by Physician or other Authorized Provider Type with one patient; first thirty (30) minutes of patient faceto-face time. Additional (30) minute increments are authorized in accordance with medical necessity.	Physician Psychiatrist Psychologist BCBA-D BCBA A BCaBA or RBT may be observed delivering the service by a Physician Psychiatrist Psychologist BCBA-D BCBA
Adaptive Behavior Treatment	Adaptive Behavior Treatment Social Skills Group is administered by a practitioner in a social skills group. The practitioner monitors the needs of the individual and adjusts therapeutic techniques in real-time to address targeted social deficits and problem behaviors using modeling, rehearsing, and corrective feedback. The	Physician Psychologist Psychiatrist BCBA-D BCBA
Social Skills Group	practitioner develops group activities in which each patient has an opportunity to practice encounters. Adaptive Behavior Treatment Social Skills Group, administered by Physician or other Authorized Provider Type, face-to-face with multiple patients.	BCaBA RBT
Exposure Adaptive Behavior Treatment with Protocol Modification	Exposure Adaptive Behavior Treatment with Protocol Modification requires staged environmental conditions to train appropriate alternative responses under the environmental contexts that typically evoke problem behavior. Exposure adaptive behavior treatment addresses one or more specific destructive behaviors. Practitioners directs the sequence of events utilizing real time observation. Exposure Adaptive Behavior Treatment with protocol modification requiring two (2) or more Authorized Provider Type for severe maladaptive behavior(s); first sixty (60) minutes of the Authorized Provider Type's time, face to face with member. Additional (30) minute increments are authorized in accordance with medical necessity.	Physician Psychiatrist Psychologist BCBA-D BCBA A BCaBA or RBT may be observed delivering the service by a Physician Psychiatrist Psychologist BCBA-D BCBA

903.1 Covered Services by CPT or HCPCs

All services are to be billed with modifiers specific for practitioner level and service delivery setting/modality. See Appendix A for Covered Services Procedure Code and Rate Schedule.

903.2 Medicare Deductible/Coinsurance

If a member is eligible for both Medicaid and Medicare, all claims must be sent to the Medicare carrier first. Medicare upper limits of reimbursement will apply for all services covered by Medicare. Policies and procedures for billing these services and detailed coverage limitations are described in Chapter 300 of Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual and Chapter 1000 of this manual.

APPENDIX A

2019 Adaptive Behavior Services (ABS) Codes and Rates

Effective January 1, 2019, the Department of Community Health (DCH) and Gainwell Technology updated the Georgia Medicaid Management Information System (GAMMIS) with the 2019 Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) of new Autism Spectrum Disorder (ASD) procedure codes. The Centers for Medicaid and Medicare Services (CMS) notified State Medicaid Agencies of the revised HCPCS/CPT codes.
Accordingly, some of the HCPCS/CPT codes that were previously assigned to the GA Medicaid Autism program (Category of Service 445) were terminated on December 31, 2018, and the new replacement ASD procedure codes were implemented on January 1, 2019. The new 2019 ABS procedure codes replaced the majority of the T-Codes and also the time-based units of measures were revised. Rates that were associated with the T-Codes were applied and adjusted to the new replacement codes with applicable unit changes.

Below is the listing of the 2019 replacement codes and description of services. Also refer to Appendix F for the cross-walk table that links the new ASD procedures codes to the old Autism T-codes.

Autism Assessment, Therapies and Supports					
2019 Category I/III CPT Codes for Adaptive Behavior Services Description	2019 Procedure Code	Practitioner Level Modifier	Service Location	Unit	Rate
Behavior identification assessment, administered by a physician or other qualified healthcare professional, each 15 minutes of the physician's or other qualified healthcare profession's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan	97151	U1	U6	15 mins	58.21
		U2	U6	15 mins	38.97
		U3	U6	15 mins	30.01
		U1	GT	15 mins	58.21
		U2	GT	15 mins	38.97
		U3	GT	15 mins	30.01
		U1	U7	15 mins	74.09
		U2	U7	15 mins	46.76
		U3	U7	15 mins	36.68
		U1	U6	15 mins	58.21

Behavior Identification Supporting assessment, administered by one technician under the direction of a physician or other qualified healthcare professional, face-to-face with the patient, each 15 minute	97152	U2	U6	15 mins	38.97
		U3	U6	15 mins	30.01
		U4	U6	15 mins	20.30
		U5	U6	15 mins	15.13
		U1	GT	15 mins	58.21
		U2	GT	15 mins	38.97
		U3	GT	15 mins	30.01
		U4	GT	15 mins	20.30
		U5	GT	15 mins	15.13
		U1	U7	15 mins	74.09
		U2	U7	15 mins	46.76
		U3	U7	15 mins	36.68
		U4	U7	15 mins	24.36
		U5	U7	15 mins	18.15

Autism Assessment, Therapies and Supports					
Service Description	Procedure	Practitioner Level Modifier	Service Location	Unit	Rate
Behavior identification supporting assessment, each 15 minutes of technician' time face-to-face with a patient, requiring the following components: a) administered by the physician or other qualified healthcare professional who is on site; b) with the assistance of two or more technicians; c) for a patient who exhibits destructive behavior; d) completed in an environment that is customized to the patient's behavior	0362T	U1	U6	15 mins	58.21
	0362T	U2	U6	15 mins	38.97
	0362T	U3	U6	15 mins	30.01
	0362T	U4	U6	15 mins	20.30
	0362T	U5	U6	15 mins	15.13
	0362T	U1	GT	15 mins	58.21
	0362T	U2	GT	15 mins	38.97
	0362T	U3	GT	15 mins	30.01
	0362T	U4	GT	15 mins	20.30
	0362T	U5	GT	15 mins	15.13
	0362T	U1	U7	15 mins	74.09
	0362T	U2	U7	15 mins	46.76
	0362T	U3	U7	15 mins	36.68
	0362T	U4	U7	15 mins	24.36

	0362T	U5	U7	15 mins	18.15
Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional, face-to-face with one patient, each 15 minutes	97153	U1	U6	15 mins	58.21
		U2	U6	15 mins	38.97
		U3	U6	15 mins	30.01
		U4	U6	15 mins	20.30
		U5	U6	15 mins	15.13
		U1	GT	15 mins	58.21
		U2	GT	15 mins	38.97
		U3	GT	15 mins	30.01
		U4	GT	15 mins	20.30
		U5	GT	15 mins	15.13
		U1	U7	15 mins	74.09
		U2	U7	15 mins	46.76
		U3	U7	15 mins	36.68
		U4	U7	15 mins	24.36
		U5	U7	15 mins	18.15

Autism Assessment, Therapies and Supports					
Service Description	Procedure	Practitioner Level Modifier	Service Location	Unit	Rate
Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional, face-to-face with two or more patients, each 15 minutes	97154	U1	U6	15 mins	58.21
		U2	U6	15 mins	38.97
		U3	U6	15 mins	30.01
		U4	U6	15 mins	20.30
		U5	U6	15 mins	15.13

		U1	GT	15 mins	58.21
		U2	GT	15 mins	38.97
		U3	GT	15 mins	30.01
		U4	GT	15 mins	20.30
		U5	GT	15 mins	15.13
		U1	U7	15 mins	74.09
		U2	U7	15 mins	46.76
		U3	U7	15 mins	36.68
		U4	U7	15 mins	24.36
		U5	U7	15 mins	18.15
Adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes	97155	U1	U6	15 mins	58.21
		U2	U6	15 mins	38.97
		U3	U6	15 mins	30.01
		U1	GT	15 mins	58.21
		U2	GT	15 mins	38.97
		U3	GT	15 mins	30.01
		U1	U7	15 mins	74.09
		U2	U7	15 mins	46.76
		U3	U7	15 mins	36.68

Autism Assessment, Therapies and Supports					
Service Description	Procedure	Practitioner Level Modifier	Service Location	Unit	Rate
		U1	U6	15 mins	21.90

Family adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes	97156	U2	U6	15 mins	17.01
		U3	U6	15 mins	13.21
		U1	GT	15 mins	21.90
		U2	GT	15 mins	17.01
		U3	GT	15 mins	13.21
		U1	U7	15 mins	26.72
		U2	U7	15 mins	20.78
		U3	U7	15 mins	16.51
Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes	97157	U1	U6	15 mins	25.34
		U2	U6	15 mins	17.00
		U3	U6	15 mins	13.21
		U1	GT	15 mins	25.34
		U2	GT	15 mins	17.00
		U3	GT	15 mins	13.21
		U1	U7	15 mins	30.97
		U2	U7	15 mins	20.78
		U3	U7	15 mins	16.51

Autism Assessment, Therapies and Supports					
Service Description	Procedure	Practitioner Level Modifier	Service Location	Unit	Rate
Group adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, face-to-face with multiple patients, each 15 minutes	97158	U1	U6	15 mins	25.34
		U2	U6	15 mins	17.00
		U3	U6	15 mins	13.21

		U1	GT	15 mins	25.34
		U2	GT	15 mins	17.00
		U3	GT	15 mins	13.21
		U1	U7	15 mins	30.97
		U2	U7	15 mins	20.78
		U3	U7	15 mins	16.51
Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: - administered by the physician or other qualified healthcare professional who is on site; - with the assistance of two or more technicians; - for a patient who exhibits destructive behavior; - completed in an environment that is customized, to the patient's behavior	0373T	U1	U6	15 mins	58.21
	0373T	U2	U6	15 mins	38.97
	0373T	U3	U6	15 mins	30.01
	0373T	U4	U6	15 mins	20.30
	0373T	U5	U6	15 mins	15.13
	0373T	U1	GT	15 mins	58.21
	0373T	U2	GT	15 mins	38.97
	0373T	U3	GT	15 mins	30.01
	0373T	U4	GT	15 mins	20.30
	0373T	U5	GT	15 mins	15.13
	0373T	U1	U7	15 mins	74.09
	0373T	U2	U7	15 mins	46.76
	0373T	U3	U7	15 mins	36.68
	0373T	U4	U7	15 mins	24.36
	0373T	U5	U7	15 mins	18.15

Daily Max Units per Procedure code as Mandated by CMS, effective 7/1/2021

Procedure Code	Max Units Per Day as allowed by CMS
97151	32
97152	16
97153	32
97154	18
97155	24
97156	16
97157	16
97158	16
0362T	16
0373T	32

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Location	**Code**
In-Clinic	U6
Out-of-Clinic*	U7
Telemed	GT

**"Out-of-Clinic" is billable for delivery of ASD services in any location outside of your agency/clinic (In-clinic)*

(1) Telemedicine

Practitioner Level Legend	Level
Physician, Psychiatrist	U1 - Level 1
Psychologist, BCBA-D	U2 - Level 2
BCBA	U3 - Level 3
BCaBA	U4 - Level 4
Registered Behavior Technician	U5 - Level 5

The following providers are authorized to directly deliver ASD services:

- **Licensed Physician** (with or without BCBA certification):
  - May be the enrolled QHCP.
  - May supervise the work of BCaBAs and RBTs who implement behavior-analytic interventions.

- **Advance Nurse Practitioner** (with or without BCBA certification):
  - May be the enrolled QHCP.
  - May supervise the work of BCaBAs and RBTs who implement behavior-analytic interventions.

- **Licensed Psychologist** (with or without BCBA certification):
  - May be the enrolled QHCP.
  - May supervise the work of BCaBAs and RBTs who implement behavior-analytic interventions.

- **Board Certified Behavior Analyst- Doctoral Level** (BCBA-D):
  - A doctoral level independent practitioner qualified to provide behavior-analytic services/ direct services.
  - May be the enrolled QHCP.
  - May supervise BCaBAs, RBTs and others who implement behavior-analytic interventions

- **Board Certified Behavior Analyst** (BCBA)
  - A masters/graduate level independent practitioner qualified to provide behavior-analytic services/direct services.
  - May be the enrolled QHCP.
  - May supervise the work of BCaBAs and RBTs who implement behavior-analytic interventions.

- **Board Certified Assistant Behavior Analyst** (BCaBA):
  - Bachelor's level practitioner - May not be the enrolled QHCP.
  - Must be supervised by a physician, psychologist, or BCBA/BCBA-D
  - May supervise the work of RBTs.

- **Registered Behavior Technician** (RBT):
  - Paraprofessional who implements the service plan under supervision of a BCBA/BCBA-D
  - May not be the enrolled QHCP.
  - Must be supervised by a BCBA/BCBA-D or BCaBA

APPENDIX B

Medicaid Non-Emergency Transportation

People enrolled in the Medicaid program need to get to and from health care services, but many do not have any means of transportation. The Non-Emergency Transportation Program (NET) provides a way for Medicaid recipients to get that transportation so they can receive necessary medical services covered by Medicaid.

How do I get non-emergency transportation services?

If you are a Medicaid recipient and have no other way to get to medical care or services covered by Medicaid, you can contact a transportation broker to take you. In most cases, you must call three days in advance to schedule transportation. Urgent care situations and a few other exceptions can be arranged more quickly. Each broker has a toll-free telephone number to schedule transportation services, and is available weekdays (Monday-Friday) from 7 a.m. to 6 p.m. All counties in Georgia are grouped into five regions for NET services. A NET Broker covers each region. If you need NET services, you must contact the NET Broker serving the county you live in to ask for non-emergency transportation. See the chart below to determine which broker serves your county, and call the broker's telephone number for that region.

What if I have problems with a NET broker?

The Division of Medical Assistance (DMA) monitors the quality of the services brokers provide, handling consumer complaints and requiring periodic reports from the brokers. The state Department of Audits also performs on-site evaluations of the services provided by each broker. If you have a question, comment or complaint about a broker, call the Member CIC at 866-211-0950.

Region	Broker/Phone Number	Counties Served
North	Southeastrans Toll free 1-866-388-9844 Local 678-510-4555	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Cobb, Dade, Dawson, Douglas, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Habersham, Hall, Haralson, Jackson, Lumpkin, Morgan, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, Walton, White, and Whitfield
Atlanta	Southeastrans 404-209-4000	Fulton, DeKalb, and Gwinnett

Region	Broker/Phone Number	Counties Served
Central	ModivCare (formerly LogistiCare) Toll free 1-888-224-7981	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Dodge, Fayette, Heard, Henry, Jasper, Jones, Lamar, Laurens, Meriwether, Monroe, Newton, Pike, Putnam, Rockdale, Spalding, Telfair, Troup, Twiggs, and Wilkinson
East	ModivCare (formerly LogistiCare) Toll free 1-888-224-7988 *Note: For Crisis Stabilization Units and Psychiatric Residential Treatment Facilities: 1-800-486-7642 Ext. 461 or 436*	Appling, Bacon, Brantley, Bryan, Bulloch, Burke, Camden, Candler, Charlton, Chatham, Clarke, Columbia, Effingham, Elbert, Emanuel, Evans, Glascock, Glynn, Greene, Hancock, Hart, Jeff Davis, Jefferson, Jenkins, Johnson, Liberty, Lincoln, Long, Madison, McDuffie, McIntosh, Montgomery, Oconee, Oglethorpe, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Truetlen, Ware, Warren, Washington, Wayne, Wheeler, and Wilkes
Southwest	ModivCare (formerly LogistiCare) Toll free 1-888-224-7985	Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Clinch, Coffee, Colquitt, Cook, Crawford, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Houston, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Peach, Pulaski, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Upson, Webster, Wilcox, and Worth

APPENDIX C

Georgia Families

Georgia Families® (GF) is a statewide program designed to deliver health care services to members of Medicaid, PeachCare for Kids®, and Planning for Healthy Babies® (P4HB) recipients. The program is a partnership between the Department of Community Health (DCH) and private care management organizations (CMOs). By providing a choice of health plans, Georgia Families allows members to select a health care plan that fits their needs.

It is important to note that GF is a full-risk program; this means that the three CMOs licensed in Georgia to participate in GF are responsible and accept full financial risk for providing and authorizing covered services. This also means a greater focus on case and disease management with an emphasis on preventative care to improve individual health outcomes.

The three licensed CMOs:

Amerigroup Community Care 1-800-454-3730 www.amerigroup.com	Peach State Health Plan 866-874-0633 www.pshpgeorgia.com	CareSource 1-855-202-1058 www.caresource.com

Children, parent/caretaker with children, pregnant women and women with breast or cervical cancer on Medicaid, as well as children enrolled in PeachCare for Kids® are eligible to participate in Georgia Families. Additionally, Planning for Healthy Babies® (P4HB) recipients receive services through Georgia Families® (GF). Children in foster care or receiving adoption assistance and certain youths committed to juvenile justice are enrolled in Georgia Families 360°.

Eligibility Categories for Georgia Families:

Included Populations	Excluded Populations
Parent/Caretaker with Children	Aged, Blind and Disabled
Transitional Medicaid	Nursing home
Pregnant Women (Right from the Start Medicaid – RSM)	Long-term care (Waivers, SOURCE)
Children (Right from the Start Medicaid – RSM)	Federally Recognized Indian Tribe
Children (newborn)	Georgia Pediatric Program (GAPP)
Women Eligible Due to Breast and Cervical Cancer	Hospice
PeachCare for Kids®	Children's Medical Services program
Parent/Caretaker with Children	Medicare Eligible
Children under 19	Supplemental Security Income (SSI) Medicaid
Women's Health Medicaid (WHM)	Medically Needy
Refugees	Recipients enrolled under group health plans
Planning for Healthy Babies®	Individuals enrolled in a Community Based Alternatives for Youths (CBAY)
Resource Mothers Outreach	

Medicaid and PeachCare for Kids® members will continue to be eligible for the same services they receive through traditional Medicaid and state Value Added Benefits. Members will not have to pay more than they paid for Medicaid co-payments or PeachCare for Kids® premiums. With a focus on health and wellness, the CMOs will provide members with health education and prevention programs giving them the tools needed to live healthier lives. Providers participating in Georgia Families will have the added assistance of the CMOs to educate members about accessing care, referrals to specialists, member benefits, and health and wellness education. **All three CMOs are State-wide.**

The Department of Community Health has contracted with three CMOs to provide these services:

- Amerigroup Community Care
- CareSource
- Peach State Health Plan

Members can contact Georgia Families for assistance to determine which program best fits their family's needs. If members do not select a plan, Georgia Families will select a health plan for them.

Members can visit the Georgia Families Web site at www.georgia-families.com or call 1-800-GA-ENROLL (1-888-423-6765) to speak to a representative who can give them information about the CMOs and the health care providers.

The following categories of eligibility are included and excluded under Georgia Families:

Included Categories of Eligibility (COE):

COE	DESCRIPTION
104	LIM – Adult
105	LIM – Child
118	LIM – 1st Yr Trans Med Ast Adult
119	LIM – 1st Yr Trans Med Ast Child
122	CS Adult 4 Month Extended
123	CS Child 4 Month Extended
135	Newborn Child
170	RSM Pregnant Women
171	RSM Child
180	P4HB Inter Pregnancy Care
181	P4HB Family Planning Only
182	P4HB ROMC - LIM
183	P4HB ROMC - ABD
194	RSM Expansion Pregnant Women
195	RSM Expansion Child < 1 Yr
196	RSM Expn Child w/DOB < = 10/1/83
197	RSM Preg Women Income < 185 FPL
245	Women's Health Medicaid
471	RSM Child
506	Refugee (DMP) – Adult
507	Refugee (DMP) – Child
508	Post Ref Extended Med – Adult
509	Post Ref Extended Med – Child
510	Refugee MAO – Adult
511	Refugee MAO – Child

571	Refugee RSM - Child
595	Refugee RSM Exp. Child < 1
596	Refugee RSM Exp Child DOB </= 10/01/83
790	Peachcare < 150% FPL
791	Peachcare 150 – 200% FPL
792	Peachcare 201 – 235% FPL
793	Peachcare > 235% FPL
835	Newborn
836	Newborn (DFACS)
871	RSM (DHACS)
876	RSM Pregnant Women (DHACS)
894	RSM Exp Pregnant Women (DHACS)
895	RSM Exp Child < 1 (DHACS)
897	RSM Pregnant Women Income > 185% FPL (DHACS)
898	RSM Child < 1 Mother has Aid = 897 (DHACS)
918	LIM Adult
919	LIM Child
920	Refugee Adult
921	Refugee Child

Excluded Categories of Eligibility (COE):

COE	DESCRIPTION
124	Standard Filing Unit – Adult
125	Standard Filing Unit – Child
131	Child Welfare Foster Care
132	State Funded Adoption Assistance
147	Family Medically Needy Spend down
148	Pregnant Women Medical Needy Spend down
172	RSM 150% Expansion
180	Interconceptional Waiver
210	Nursing Home – Aged
211	Nursing Home – Blind
212	Nursing Home – Disabled
215	30 Day Hospital – Aged
216	30 Day Hospital – Blind
217	30 Day Hospital – Disabled
218	Protected Med/1972 Cola - Aged
219	Protected Med/1972 Cola – Blind
220	Protected Med/1972 Cola - Disabled
221	Disabled Widower 1984 Cola - Aged
222	Disabled Widower 1984 Cola – Blind
223	Disabled Widower 1984 Cola – Disabled
224	Pickle - Aged
225	Pickle – Blind
226	Pickle – Disabled

227	Disabled Adult Child - Aged
227	Disabled Adult Child - Aged
229	Disabled Adult Child – Disabled
230	Disabled Widower Age 50-59 – Aged
231	Disabled Widower Age 50-59 – Blind
232	Disabled Widower Age 50-59 – Disabled
233	Widower Age 60-64 – Aged
234	Widower Age 60-64 – Blind
235	Widower Age 60-64 – Disabled
236	3 Mo. Prior Medicaid – Aged
237	3 Mo. Prior Medicaid – Blind
238	3 Mo. Prior Medicaid – Disabled
239	Abd Med. Needy Defacto – Aged
240	Abd Med. Needy Defacto – Blind
241	Abd Med. Needy Defacto – Disabled
242	Abd Med Spend down – Aged
243	Abd Med Spend down – Blind
244	Abd Med Spend down – Disabled
246	Ticket to Work
247	Disabled Child – 1996
250	Deeming Waiver
251	Independent Waiver
252	Mental Retardation Waiver
253	Laurens Co. Waiver
254	HIV Waiver
255	Cystic Fibrosis Waiver
259	Community Care Waiver
280	Hospice – Aged
281	Hospice – Blind
282	Hospice – Disabled
283	LTC Med. Needy Defacto – Aged
284	LTC Med. Needy Defacto –Blind
285	LTC Med. Needy Defacto – Disabled
286	LTC Med. Needy Spend down – Aged
287	LTC Med. Needy Spend down – Blind
288	LTC Med. Needy Spend down – Disabled
289	Institutional Hospice – Aged
290	Institutional Hospice – Blind
291	Institutional Hospice – Disabled
301	SSI – Aged
302	SSI – Blind
303	SSI – Disabled
304	SSI Appeal – Aged
305	SSI Appeal – Blind
306	SSI Appeal – Disabled
307	SSI Work Continuance – Aged

309	SSI Work Continuance – Disabled
308	SSI Work Continuance – Blind
315	SSI Zebley Child
321	SSI E02 Month – Aged
322	SSI E02 Month – Blind
323	SSI E02 Month – Disabled
387	SSI Trans. Medicaid – Aged
388	SSI Trans. Medicaid – Blind
389	SSI Trans. Medicaid – Disabled
410	Nursing Home – Aged
411	Nursing Home – Blind
412	Nursing Home – Disabled
424	Pickle – Aged
425	Pickle – Blind
426	Pickle – Disabled
427	Disabled Adult Child – Aged
428	Disabled Adult Child – Blind
429	Disabled Adult Child – Disabled
445	N07 Child
446	Widower – Aged
447	Widower – Blind
448	Widower – Disabled
460	Qualified Medicare Beneficiary
466	Spec. Low Inc. Medicare Beneficiary
575	Refugee Med. Needy Spend down
660	Qualified Medicare Beneficiary
661	Spec. Low Income Medicare Beneficiary
662	Q11 Beneficiary
663	Q12 Beneficiary
664	Qua. Working Disabled Individual
815	Aged Inmate
817	Disabled Inmate
870	Emergency Alien – Adult
873	Emergency Alien – Child
874	Pregnant Adult Inmate
915	Aged MAO
916	Blind MAO
917	Disabled MAO
983	Aged Medically Needy
984	Blind Medically Needy
985	Disabled Medically Needy

HEALTH CARE PROVIDERS

For information regarding the participating health plans (enrollment, rates, and procedures), please call the numbers listed below.

Prior to providing services, you should contact the member's health plan to verify eligibility, PCP assignment and covered benefits. You should also contact the health plan to check prior authorizations and submit claims.

Amerigroup Community Care	CareSource	Peach State Health Plan
800-454-3730 (general information) www.amerigroup.com	1-855-202-1058 www.careSource.com/Georgia Medicaid	866-874-0633 (general information) 866-874-0633 (claims) 800-704-1483 (medical management) www.pshpgeorgia.com

Registering immunizations with GRITS:

If you are a Vaccine for Children (VFC) provider, please continue to use the GRITS (Georgia Immunization Registry) system for all children, including those in Medicaid and PeachCare for Kids®, fee-for-service, and managed care.

Important tips for the provider to know/do when a member comes in:

Understanding the process for verifying eligibility is now more important than ever. You will need to determine if the patient is eligible for Medicaid/PeachCare for Kids® benefits and if they are enrolled in a Georgia Families health plan. Each plan sets its own medical management and referral processes. Members will have a new identification card and primary care provider assignment.

You may also contact GAINWELL TECHNOLOGIES at 1-800-766-4456 (statewide) or www.mmis.georgia.gov for information on a member's health plan.

Use of the Medicaid Management Information System (MMIS) web portal:

The call center and web portal will be able to provide you information about a member's Medicaid eligibility and health plan enrollment. GAINWELL TECHNOLOGIES will **not** be able to assist you with benefits, claims processing or prior approvals for members assigned to a Georgia Families health plan. You will need to contact the member's plan directly for this information.

Participating in a Georgia Families' health plan:

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:

For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to GAINWELL TECHNOLOGIES in error:

GAINWELL TECHNOLOGIES will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Credentialing

Effective August 1, 2015, Georgia's Department of Community Health (DCH) implemented a NCQA certified Centralized Credentialing Verification Process utilizing a Credentialing Verification Organization (CVO). This functionality has been added to the Georgia Medicaid Management Information System (GAMMIS) website (www.MMIS.georgia.gov) and has streamlined the time frame that it takes for a provider to be fully credentialed.

Credentialing and recredentialing services is provided for Medicaid providers enrolled in Georgia Families and/or the Georgia Families 360° program.

This streamlined process results in administrative simplification thereby preventing inconsistencies, as well as the need for a provider to be credentialed or recredentialed multiple times.

The CVO's one-source application process:

- Saves time
- Increases efficiency
- Eliminates duplication of data needed for multiple CMOs
- Shortens the time period for providers to receive credentialing and recredentialing decisions

The CVO will perform primary source verification, check federal and state databases, obtain information from Medicare's Provider Enrollment Chain Ownership System (PECOS), check required medical malpractice insurance, confirm Drug Enforcement Agency (DEA) numbers, etc. A Credentialing Committee will render a decision regarding the provider's credentialing status. Applications that contain all required credentialing and recredentialing materials at the time of submission will receive a decision within 45 calendar days. Incomplete applications that do not contain all required credentialing documents will be returned to the provider with a request to supplement all missing materials. Incomplete applications may result in a delayed credentialing or recredentialing decision. The credentialing decision is provided to the CMOs.

GAINWELL TECHNOLOGIES provider reps will provide training and assistance as needed. Providers may contact GAINWELL TECHNOLOGIES for assistance with credentialing and recredentialing by dialing 1-800-766-4456.

Assignment of separate provider numbers by all of the health plans:

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:

For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to GAINWELL TECHNOLOGIES in error:

GAINWELL TECHNOLOGIES will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Receiving payment:

Claims should be submitted to the member's health plan. Each health plan has its own claims processing and you should consult the health plan about their payment procedures.

Health plans payment of clean claims:

Each health plan (and subcontractors) has its own claims processing and payment cycles. The claims processing and payment timeframes are as follows:

Amerigroup Community Care	CareSource	Peach State Health Plan
Amerigroup runs claims cycles twice each week (on Monday and Thursday) for **clean** claims that have been adjudicated. Monday Claims run: Checks mailed on Tuesday. Providers enrolled in ERA/EFT receive the ACH on Thursday. Thursday Claims run: Checks mailed on Wednesday. Providers enrolled in ERA/EFT receive the ACH on Tuesday. **Dental:** Checks are mailed weekly on Thursday for **clean** claims. **Vision**: Checks are mailed weekly on Wednesday for **clean** claims (beginning June 7th) **Pharmacy**: Checks are mailed to pharmacies weekly on Friday (except when a holiday falls on Friday, then mailed the next business day)	CareSource runs claims cycles twice each week on Saturdays and Tuesdays for clean claims that have been adjudicated. Pharmacy: Payment cycles for pharmacies is weekly on Wednesdays.	Peach State has two weekly claims payment cycles per week that produces payments for **clean** claims to providers on Monday and Wednesday. For further information, please refer to the Peach State website, or the Peach State provider manual.

How often can a patient change his/her PCP?

Amerigroup Community Care	CareSource	Peach State Health Plan
Anytime	Members can change their PCP one (1) time per month. However, members can change their PCP at any time under extenuating circumstances such as: • Member requests to be assigned to a family member's PCP • PCP does not provide the covered services a member seeks	Within the first 90 days of a member's enrollment, he/she can change PCP monthly. If the member has been with the plan for 90 days or longer, the member can change PCPs once every six months. There are a few exclusions that apply and would warrant an immediate PCP change.

	due to moral or religious objections • PCP moves, retires, etc.	

Once the patient requests a PCP change, how long it takes for the new PCP to be assigned:

Amerigroup Community Care	CareSource	Peach State Health Plan
Next business day	PCP selections are updated in CareSource's systems daily.	PCP changes made before the 24th day of the month and are effective for the current month. PCP changes made after the 24th day of the month are effective for the first of the following month.

PHARMACY

Georgia Families does provide pharmacy benefits to members. Check with the member's health plan about who to call to find out more about enrolling to provide pharmacy benefits, including information about their plans reimbursement rates, specific benefits that are available, including prior approval requirements.

To request information about contracting with the health plans, you can call the CMOs provider enrollment services.

Amerigroup Community Care	CareSource	Peach State Health Plan
800-454-3730 https://providers.amerigroup.com/pages/ga-2012.aspx	844-441-8024 https://cvs.az1.qualtrics.com/jfe/form/SV_cvyY0ohqT2VXYod	866-874-0633 www.pshpgeorgia.com

All providers must be enrolled as a Medicaid provider to be eligible to contract with a health plan to provide services to Georgia Families members.

The CMO Pharmacy Benefit Managers (PBM) and the Bin Numbers, Processor Control Numbers and Group Numbers are:

Health Plan	PBM	BIN #	PCN #	GROUP #	Helpdesk
Amerigroup Community Care	IngenioRx	020107	HL	WKJA	1-833-235-2031
CareSource	Express Scripts (ESI)	003858	MA	RXINN01	1-800-416-3630
Peach State Health Plan	CVS	004336	MCAIDADV	RX5439	1-844-297-0513

If a patient does not have an identification card:

Providers can check the enrollment status of Medicaid and PeachCare for Kids® members through GAINWELL TECHNOLOGIES by calling 1-800-766-4456 or going to the web portal at www.mmis.georgia.gov. GAINWELL TECHNOLOGIES will let you know if the member is eligible for services and the health plan they are enrolled in. You can contact the member's health plan to get the member's identification number.

Use of the member's Medicaid or PeachCare for Kids® identification number to file a pharmacy claim:

Amerigroup Community Care	CareSource	Peach State Health Plan
No, you will need the member's health plan ID number	Yes, you may also use the health plan ID number.	Yes

Health plans preferred drug list, prior authorization criteria, benefit design, and reimbursement rates:

Each health plan sets their own procedures, including preferred drug list, prior authorization criteria, benefit design, and reimbursement rates.

Will Medicaid cover prescriptions for members that the health plans do not?

No, Medicaid will not provide a "wrap-around" benefit for medications not covered or approved by the health plan. Each health plan will set its own processes for determining medical necessity and appeals.

Who to call to request a PA:

Amerigroup Community Care	CareSource	Peach State Health Plan
1 (800) 454-3730	1 (855) 202-1058 1 (866) 930-0019 (fax)	1 (866) 399-0929

APPENDIX D

Information for Providers Serving Medicaid Members

in the Georgia Families 360 SM Program

Georgia Families 360SM, the state's managed care program for children, youth, and young adults in Foster Care, children and youth receiving Adoption Assistance, as well as select youth in the juvenile justice system, launched Monday, March 3, 2014. Amerigroup Community Care is the single Care Management Organization (CMO) that will be managing this population.

Amerigroup is responsible, through its provider network, for coordinating all DFCS, DJJ required assessments and medically necessary services for children, youth and young adults who are eligible to participate in the Georgia Families 360SM Program. Amerigroup will coordinate all medical/dental/trauma assessments for youth upon entry into foster care or juvenile justice (and as required periodically).

Georgia Families 360SM Every member in Georgia Families 360 is assigned a Care Coordinator who works closely with them to ensure access to care and ensure that appropriate, timely, and trauma informed care is provided for acute conditions as well as ongoing preventive care. This ensures that all medical, dental, and behavioral health issues are addressed. Members also have a medical and dental home to promote consistency and continuity of care. The medical and dental homes coordinate care and serve as a place where the child is known over time by providers who can provide holistic care. DFCS, DJJ, foster parents, adoptive parents and other caregivers are involved in the ongoing health care plans to ensure that the physical and behavioral health needs of these populations are met.

Electronic Health Records (EHRs) are being used to enhance effective delivery of care. The EHRs can be accessed by Amerigroup, physicians in the Amerigroup provider network, and DCH sister agencies, including the DFCS, regardless of where the child lives, even if the child experiences multiple placements. Ombudsman and advocacy staff are in place at both DCH and Amerigroup to support caregivers and members, assisting them in navigating the health care system. Additionally, medication management programs are in place to focus on appropriate monitoring of the use of psychotropic medications, to include ADD/ADHD as well as other behavioral health prescribedmedications.

Providers can obtain additional information by contacting the Provider Service Line at 1-800-454-3730 or by contacting their Provider Relations representative.

To learn more about DCH and its dedication to A Healthy Georgia, visit www.dch.georgia.gov

APPENDIX E

2019 Autism Code Crosswalk

2018 Procedure Code	2018 Description	Unit		2019 Procedure Code	2019 Category I/III CPT Codes for Adaptive Behavior Services	Unit
0359T	Behavior identification assessment by the physician or other qualified healthcare professional, face-to-face with patient and caregiver(s), includes administration of standardized and non standardized tests, detailed behavioral history, patient obervation and caregiver interview, interpretation of test results, discussion of findings and recommendations with theprimary guardian(s)/caregiver(s), and preparation of report. [Untimed]	90 mins		97151	Behavior identification assessment, administered by a physician or other qualified healthcare professional, each 15 minutes of the physician's or other qualified healthcare profession's time face-to-face with patien and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non face-to-tace analyzing past data, scoring/interpreting the assessment, and preparing the report/treament plan	15 mins
0360T	Observational behavioral follow-up assessment. Includes physician or other qualified healthcare professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-toface with the patient	30 mins		97152	Behavior Identification Supporting assessment, administered by one technician under the direction of a physician or other qualified healthcare professional, face-to-face with the patient, each 15 minute	15 mins
0361T	Observational behavioral follow-up assessment, each additional 30 minutes of technician time, face-to-face with the patient (list separatey in addition to code for primary procedure).	30 mins		97152	Behavior Identification Supporting assessment, administered by one technician under the direction of a physician or other qualified healthcare professional, face-to-face with the patient, each 15 minute	15 mins

2018 Procedure Code	2018 Description	Unit		2019 Procedure Code	2019 Category I/III CPT Codes for Adaptive Behavior Services	Unit
0363T	Exposure behavioral follow-up assessment, each additional 30 minutes of technician(s) time, face-to-face with the patient (list separately in addition to code for primary procedure).	30 mins		0362T	Behavior identification supporting assessment, each 15 minutes of technician' time face-toface with a patieng, requiring the following components: a) administered by the physician or other qualified healthcare prfessional who is on site; b)with the assistance of tow or more technicians; c) for a patien who exhibits destructive behavior; d) completed in an enviroment that is customized to the patient's behavior	15 mins
0364T	Adaptive behavior treatment by protocol administered by technician, face-to-face with one patient; first 30 minutes of technician time.	30 mins		97153	Adaptive behavior treatment by protocol, adminsitered by technician under the direction of a physician or other qualified healthcare professional, face-to-face with one patient, each 15 minutes	15 mins
0365T	Adaptive behavior treatment by protocol, each additional 30 minutes of technician time (list seperately in addition to code for primary procedure	30 mins		97153	Adaptive behavior treatment by protocol, adminsitered by technician under the direction of a physician or other qualified healthcare professional, face-to-face with one patient, each 15 minutes	15 min
0366T	Group adaptive behavior treatment by protocol administered by technician, faceto-face with two more patiens; first 30 minutes of technician time	30 mins		97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professiona, face-to-face with two or more patients, each 15 minutes	15 mins

0367T	Group adaptive behavior treatment by protocol, each additional 30 minutes of technician time (list separately in addition to code for primary procedure)	30 mins		97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professiona, face-to-face with two or more patients, each 15 minutes	15 mins

2018 Procedure Code	2018 Description	Unit		2019 Procedure Code	2019 Category I/III CPT Codes for Adaptive Behavior Services	Unit
0368T	Adaptive behavior treatment with protocol modification administered by physician or other qualifed healthcare professional with one patient; first 30 minutes of patient face-to-face time	30 mins		97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualifed healthcare professional, which may include simultaneours direction of technician, face-to-face with one patient, each 15 minutes	15 mins
0369T	Adaptive behavior treatment with protocol modification adminsitered by physician or other qualified healthcare professional with one patient; each additional 30 minutes of patient face-to-face time (list separately in addition to code for primary procedure).	30 mins		97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualifed healthcare professional, which may include simultaneours direction of technician, face-to-face with one patient, each 15 minutes	15 mins
0370T	Family adaptive behavior treatment guidance administered by physican or other qualified healthcare professional (without the patient present). [untimed]	60 mins		97156	Family adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes	15 mins
0371T	Multiple-family group adaptive behavior treatment guidance administered by physician or other qualifier healthcare provessional (without the patient present) [untimed]	90 mins		97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified healcare professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes	15 mins

0372T	Adaptive behavior treatment social skills group administered by physican or other qualified healthcare professional face-toface with multiple patients. [untimed]	90 mins		97158	Group adaptive behavior treatment with protocol modification, administered by physiciian or other qualified healthcare prfessional, face-to-face with multiple patients, each 15 minutes	15 mins
2018 Procedure Code	**2018 Description**	**Unit**		**2019 Procedure Code**	**2019 Category I/III CPT Codes for Adaptive Behavior Services**	**Unit**
0374T	Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); each additional 30 minutes of technicians' time face-to-face with patient (list separately in addition to code for primary procedure)	30 mins		0373T	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: *administered by the physician or other qualified healthcare professional who is on site; *with the assistance of two or more technicians; *for a patient who exhibits destructive behavior; *completed in an environment that is customized, to the patient's behavior	15 mins

2018 Procedure Code	Practitioner	Service Location	Unit	Rate	2019 Procedure Code	Practitioner	Service Location	Unit	Rate
0359T	U1	U6	90 mins	$349.26	97151	U1	U6	15 min	$58.21
0359T	U2	U6	90 mins	$233.80	97151	U2	U6	15 min	$38.97
0359T	U3	U6	90 mins	$180.06	97151	U3	U6	15 min	$30.01
0359T	U1	GT	90 mins	$349.26	97151	U1	GT	15 min	$58.21
0359T	U2	GT	90 mins	$233.80	97151	U2	GT	15 min	$38.97
0359T	U3	GT	90 mins	$180.06	97151	U3	GT	15 min	$30.01
0359T	U1	U7	90 mins	$444.54	97151	U1	U7	15 min	$74.09
0359T	U2	U7	90 mins	$280.56	97151	U2	U7	15 min	$46.76
0359T	U3	U7	90 mins	$220.07	97151	U3	U7	15 min	$36.68
0360T	U1	U6	30 mins	$116.42	97152	U1	U6	15 mins	$58.21
0360T	U2	U6	30 mins	$77.94	97152	U2	U6	15 mins	$38.97
0360T	U3	U6	30 mins	$60.02	97152	U3	U6	15 mins	$30.01
0360T	U4	U6	30 mins	$40.60	97152	U4	U6	15 mins	$20.30
0360T	U5	U6	30 mins	$30.26	97152	U5	U6	15 mins	$15.13

0360T	U1	GT	30 mins	$116.42	97152	U1	GT	15 mins	$58.21
0360T	U2	GT	30 mins	$77.94	97152	U2	GT	15 mins	$38.97
0360T	U3	GT	30 mins	$60.02	97152	U3	GT	15 mins	$30.01
0360T	U4	GT	30 mins	$40.60	97152	U4	GT	15 mins	$20.30
0360T	U5	GT	30 mins	$30.26	97152	U5	GT	15 mins	$15.13
0360T	U1	U7	30 mins	$148.18	97152	U1	U7	15 mins	$74.09
0360T	U2	U7	30 mins	$93.52	97152	U2	U7	15 mins	$46.76
0360T	U3	U7	30 mins	$73.36	97152	U3	U7	15 mins	$36.68
0360T	U4	U7	30 mins	$48.72	97152	U4	U7	15 mins	$24.36
0360T	U5	U7	30 mins	$36.30	97152	U5	U7	15 mins	$18.15
0361T	U1	U6	30 mins	$116.42	97152	U1	U6	15 mins	$58.21
0361T	U2	U6	30 mins	$77.94	97152	U2	U6	15 mins	$38.97
0361T	U3	U6	30 mins	$60.02	97152	U3	U6	15 mins	$30.01
0361T	U4	U6	30 mins	$40.60	97152	U4	U6	15 mins	$20.30
0361T	U5	U6	30 mins	$30.26	97152	U5	U6	15 mins	$15.13
0361T	U1	GT	30 mins	$116.42	97152	U1	GT	15 mins	$58.21
0361T	U2	GT	30 mins	$77.94	97152	U2	GT	15 mins	$38.97

0361T	U3	GT	30 mins	$60.02	97152	U3	GT	15 mins	$30.01
0361T	U4	GT	30 mins	$40.60	97152	U4	GT	15 mins	$20.30
0361T	U5	GT	30 mins	$30.26	97152	U5	GT	15 mins	$15.13
0361T	U1	U7	30 mins	$148.18	97152	U1	U7	15 mins	$74.09
0361T	U2	U7	30 mins	$93.52	97152	U2	U7	15 mins	$46.76
0361T	U3	U7	30 mins	$73.36	97152	U3	U7	15 mins	$36.68
0361T	U4	U7	30 mins	$48.72	97152	U4	U7	15 mins	$24.36
0361T	U5	U7	30 mins	$36.30	97152	U5	U7	15 mins	$18.15
~~0362T~~	~~U1~~	~~U6~~	~~30 mins~~	~~$116.42~~	NOT BEING DISCONTINUED BUT UNIT AMOUNT CHANGES TO 15				
	~~U2~~	~~U6~~	~~30 mins~~	~~$77.94~~					
	~~U3~~	~~U6~~	~~30 mins~~	~~$60.02~~					
	~~U4~~	~~U6~~	~~30 mins~~	~~$40.60~~					
	~~U5~~	~~U6~~	~~30 mins~~	~~$30.26~~					
	~~U1~~	~~GT~~	~~30 mins~~	~~$116.42~~					
	~~U2~~	~~GT~~	~~30 mins~~	~~$77.94~~					
	~~U3~~	~~GT~~	~~30 mins~~	~~$60.02~~					

	~~U4~~	~~GT~~	~~30 mins~~	~~$40.60~~					
	~~U5~~	~~GT~~	~~30 mins~~	~~$30.26~~					
	~~U1~~	~~U7~~	~~30 mins~~	~~$148.18~~					
	~~U2~~	~~U7~~	~~30 mins~~	~~$93.52~~					
	~~U3~~	~~U7~~	~~30 mins~~	~~$73.36~~					
	~~U4~~	~~U7~~	~~30 mins~~	~~$48.72~~					
	~~U5~~	~~U7~~	~~30 mins~~	~~$36.30~~					
0363T	U1	U6	30 mins	$116.42	0362T	U1	U6	15 mins	$58.21
0363T	U2	U6	30 mins	$77.94	0362T	U2	U6	15 mins	$38.97
0363T	U3	U6	30 mins	$60.02	0362T	U3	U6	15 mins	$30.01
0363T	U4	U6	30 mins	$40.60	0362T	U4	U6	15 mins	$20.30
0363T	U5	U6	30 mins	$30.26	0362T	U5	U6	15 mins	$15.13
0363T	U1	GT	30 mins	$116.42	0362T	U1	GT	15 mins	$58.21
0363T	U2	GT	30 mins	$77.94	0362T	U2	GT	15 mins	$38.97
0363T	U3	GT	30 mins	$60.02	0362T	U3	GT	15 mins	$30.01
0363T	U4	GT	30 mins	$40.60	0362T	U4	GT	15 mins	$20.30

0363T	U5	GT	30 mins	$30.26	0362T	U5	GT	15 mins	$15.13
0363T	U1	U7	30 mins	$148.18	0362T	U1	U7	15 mins	$74.09
0363T	U2	U7	30 mins	$93.52	0362T	U2	U7	15 mins	$46.76
0363T	U3	U7	30 mins	$73.36	0362T	U3	U7	15 mins	$36.68
0363T	U4	U7	30 mins	$48.72	0362T	U4	U7	15 mins	$24.36
0363T	U5	U7	30 mins	$36.30	0362T	U5	U7	15 mins	$18.15
0364T	U1	U6	30 mins	$116.42	97153	U1	U6	15 mins	$58.21
0364T	U2	U6	30 mins	$77.94	97153	U2	U6	15 mins	$38.97
0364T	U3	U6	30 mins	$60.02	97153	U3	U6	15 mins	$30.01
0364T	U4	U6	30 mins	$40.60	97153	U4	U6	15 mins	$20.30
0364T	U5	U6	30 mins	$30.26	97153	U5	U6	15 mins	$15.13
0364T	U1	GT	30 mins	$116.42	97153	U1	GT	15 mins	$58.21
0364T	U2	GT	30 mins	$77.94	97153	U2	GT	15 mins	$38.97
0364T	U3	GT	30 mins	$60.02	97153	U3	GT	15 mins	$30.01
0364T	U4	GT	30 mins	$40.60	97153	U4	GT	15 mins	$20.30
0364T	U5	GT	30 mins	$30.26	97153	U5	GT	15 mins	$15.13
0364T	U1	U7	30 mins	$148.18	97153	U1	U7	15 mins	$74.09

0364T	U2	U7	30 mins	$93.52	97153	U2	U7	15 mins	$46.76
0364T	U3	U7	30 mins	$73.36	97153	U3	U7	15 mins	$36.68
0364T	U4	U7	30 mins	$48.72	97153	U4	U7	15 mins	$24.36
0364T	U5	U7	30 mins	$36.30	97153	U5	U7	15 mins	$18.15
0365T	U1	U6	30 mins	$116.42	97153	U1	U6	15 mins	$58.21
0365T	U2	U6	30 mins	$77.94	97153	U2	U6	15 mins	$38.97
0365T	U3	U6	30 mins	$60.02	97153	U3	U6	15 mins	$30.01
0365T	U4	U6	30 mins	$40.60	97153	U4	U6	15 mins	$20.30
0365T	U5	U6	30 mins	$30.26	97153	U5	U6	15 mins	$15.13
0365T	U1	GT	30 mins	$116.42	97153	U1	GT	15 mins	$58.21
0365T	U2	GT	30 mins	$77.94	97153	U2	GT	15 mins	$38.97
0365T	U3	GT	30 mins	$60.02	97153	U3	GT	15 mins	$30.01
0365T	U4	GT	30 mins	$40.60	97153	U4	GT	15 mins	$20.30
0365T	U5	GT	30 mins	$30.26	97153	U5	GT	15 mins	$15.13
0365T	U1	U7	30 mins	$148.18	97153	U1	U7	15 mins	$74.09
0365T	U2	U7	30 mins	$93.52	97153	U2	U7	15 mins	$46.76
0365T	U3	U7	30 mins	$73.36	97153	U3	U7	15 mins	$36.68

0365T	U4	U7	30 mins	$48.72	97153	U4	U7	15 mins	$24.36
0365T	U5	U7	30 mins	$36.30	97153	U5	U7	15 mins	$18.15
0366T	U1	U6	30 mins	$116.42	97154	U1	U6	15 mins	$58.21
0366T	U2	U6	30 mins	$77.94	97154	U2	U6	15 mins	$38.97
0366T	U3	U6	30 mins	$60.02	97154	U3	U6	15 mins	$30.01
0366T	U4	U6	30 mins	$40.60	97154	U4	U6	15 mins	$20.30
0366T	U5	U6	30 mins	$30.26	97154	U5	U6	15 mins	$15.13
0366T	U1	GT	30 mins	$116.42	97154	U1	GT	15 mins	$58.21
0366T	U2	GT	30 mins	$77.94	97154	U2	GT	15 mins	$38.97
0366T	U3	GT	30 mins	$60.02	97154	U3	GT	15 mins	$30.01
0366T	U4	GT	30 mins	$40.60	97154	U4	GT	15 mins	$20.30
0366T	U5	GT	30 mins	$30.26	97154	U5	GT	15 mins	$15.13
0366T	U1	U7	30 mins	$148.18	97154	U1	U7	15 mins	$74.09
0366T	U2	U7	30 mins	$93.52	97154	U2	U7	15 mins	$46.76
0366T	U3	U7	30 mins	$73.36	97154	U3	U7	15 mins	$36.68
0366T	U4	U7	30 mins	$48.72	97154	U4	U7	15 mins	$24.36
0366T	U5	U7	30 mins	$36.30	97154	U5	U7	15 mins	$18.15

0367T	U1	U6	30 mins	$116.42	97154	U1	U6	15 mins	$58.21
0367T	U2	U6	30 mins	$77.94	97154	U2	U6	15 mins	$38.97
0367T	U3	U6	30 mins	$60.02	97154	U3	U6	15 mins	$30.01
0367T	U4	U6	30 mins	$40.60	97154	U4	U6	15 mins	$20.30
0367T	U5	U6	30 mins	$30.26	97154	U5	U6	15 mins	$15.13
0367T	U1	GT	30 mins	$116.42	97154	U1	GT	15 mins	$58.21
0367T	U2	GT	30 mins	$77.94	97154	U2	GT	15 mins	$38.97
0367T	U3	GT	30 mins	$60.02	97154	U3	GT	15 mins	$30.01
0367T	U4	GT	30 mins	$40.60	97154	U4	GT	15 mins	$20.30
0367T	U5	GT	30 mins	$30.26	97154	U5	GT	15 mins	$15.13
0367T	U1	U7	30 mins	$148.18	97154	U1	U7	15 mins	$74.09
0367T	U2	U7	30 mins	$93.52	97154	U2	U7	15 mins	$46.76
0367T	U3	U7	30 mins	$73.36	97154	U3	U7	15 mins	$36.68
0367T	U4	U7	30 mins	$48.72	97154	U4	U7	15 mins	$24.36
0367T	U5	U7	30 mins	$36.30	97154	U5	U7	15 mins	$18.15
0368T	U1	U6	30 mins	$116.42	97155	U1	U6	15 mins	$58.21

0368T	U2	U6	30 mins	$77.94	97155	U2	U6	15 mins	$38.97
0368T	U3	U6	30 mins	$60.02	97155	U3	U6	15 mins	$30.01
0368T	U1	GT	30 mins	$116.42	97155	U1	GT	15 mins	$58.21
0368T	U2	GT	30 mins	$77.94	97155	U2	GT	15 mins	$38.97
0368T	U3	GT	30 mins	$60.02	97155	U3	GT	15 mins	$30.01
0368T	U1	U7	30 mins	$148.18	97155	U1	U7	15 mins	$74.09
0368T	U2	U7	30 mins	$93.52	97155	U2	U7	15 mins	$46.76
0368T	U3	U7	30 mins	$73.36	97155	U3	U7	15 mins	$36.68
0369T	U1	U6	30 mins	$116.42	97155	U1	U6	15 mins	$58.21
0369T	U2	U6	30 mins	$77.94	97155	U2	U6	15 mins	$38.97
0369T	U3	U6	30 mins	$60.02	97155	U3	U6	15 mins	$30.01
0369T	U1	GT	30 mins	$116.42	97155	U1	GT	15 mins	$58.21
0369T	U2	GT	30 mins	$77.94	97155	U2	GT	15 mins	$38.97
0369T	U3	GT	30 mins	$60.02	97155	U3	GT	15 mins	$30.01
0369T	U1	U7	30 mins	$148.18	97155	U1	U7	15 mins	$74.09
0369T	U2	U7	30 mins	$93.52	97155	U2	U7	15 mins	$46.76
0369T	U3	U7	30 mins	$73.36	97155	U3	U7	15 mins	$36.68

0370T	U1	U6	60 mins	$87.59	97156	U1	U6	15 min	$21.90
0370T	U2	U6	60 mins	$68.02	97156	U2	U6	15 min	$17.01
0370T	U3	U6	60 mins	$52.82	97156	U3	U6	15 min	$13.21
0370T	U1	GT	60 mins	$87.59	97156	U1	GT	15 min	$21.90
0370T	U2	GT	60 mins	$68.02	97156	U2	GT	15 min	$17.01
0370T	U3	GT	60 mins	$52.82	97156	U3	GT	15 min	$13.21
0370T	U1	U7	60 mins	$106.86	97156	U1	U7	15 min	$26.72
0370T	U2	U7	60 mins	$83.13	97156	U2	U7	15 min	$20.78
0370T	U3	U7	60 mins	$66.02	97156	U3	U7	15 min	$16.51

0371T	U1	U6	90 mins	$152.01	97157	U1	U6	15 min	$25.34
0371T	U2	U6	90 mins	$102.02	97157	U2	U6	15 min	$17.00
0371T	U3	U6	90 mins	$79.23	97157	U3	U6	15 min	$13.21
0371T	U1	GT	90 mins	$152.01	97157	U1	GT	15 min	$25.34
0371T	U2	GT	90 mins	$102.02	97157	U2	GT	15 min	$17.00
0371T	U3	GT	90 mins	$79.23	97157	U3	GT	15 min	$13.21
0371T	U1	U7	90 mins	$185.79	97157	U1	U7	15 min	$30.97

0371T	U2	U7	90 mins	$124.69	97157	U2	U7	15 min	$20.78
0371T	U3	U7	90 mins	$99.03	97157	U3	U7	15 min	$16.51
0372T	U1	U6	90 mins	$152.01	97158	U1	U6	15 min	$25.34
0372T	U2	U6	90 mins	$102.02	97158	U2	U6	15 min	$17.00
0372T	U3	U6	90 mins	$79.23	97158	U3	U6	15 min	$13.21
0372T	U1	GT	90 mins	$152.01	97158	U1	GT	15 min	$25.34
0372T	U2	GT	90 mins	$102.02	97158	U2	GT	15 min	$17.00
0372T	U3	GT	90 mins	$79.23	97158	U3	GT	15 min	$13.21
0372T	U1	U7	90 mins	$185.79	97158	U1	U7	15 min	$30.97
0372T	U2	U7	90 mins	$124.69	97158	U2	U7	15 min	$20.78
0372T	U3	U7	90 mins	$99.03	97158	U3	U7	15 min	$16.51
~~0373T~~	~~U1~~	~~U6~~	~~60 mins~~	~~$232.84~~	NOT BEING DISCONTINUED BUT UNIT AMOUNT CHANGES TO 15				
	~~U2~~	~~U6~~	~~60 mins~~	~~$155.88~~					
	~~U3~~	~~U6~~	~~60 mins~~	~~$120.04~~					
	~~U4~~	~~U6~~	~~60 mins~~	~~$81.20~~					
	~~U5~~	~~U6~~	~~60 mins~~	~~$60.52~~					

	~~U1~~	~~GT~~	~~60 mins~~	~~$232.84~~					
	~~U2~~	~~GT~~	~~60 mins~~	~~$155.88~~					
	~~U3~~	~~GT~~	~~60 mins~~	~~$120.04~~					
	~~U4~~	~~GT~~	~~60 mins~~	~~$81.20~~					
	~~U5~~	~~GT~~	~~60 mins~~	~~$60.52~~					
	~~U1~~	~~U7~~	~~60 mins~~	~~$296.36~~					
	~~U2~~	~~U7~~	~~60 mins~~	~~$187.04~~					
	~~U3~~	~~U7~~	~~60 mins~~	~~$146.72~~					
	~~U4~~	~~U7~~	~~60 mins~~	~~$97.44~~					
	~~U5~~	~~U7~~	~~60 mins~~	~~$72.60~~					
0374T	U1	U6	30 mins	$116.42	0373T	U1	U6	15 min	$58.21
0374T	U2	U6	30 mins	$77.94	0373T	U2	U6	15 min	$38.97
0374T	U3	U6	30 mins	$60.02	0373T	U3	U6	15 min	$30.01
0374T	U4	U6	30 mins	$40.60	0373T	U4	U6	15 min	$20.30
0374T	U5	U6	30 mins	$30.26	0373T	U5	U6	15 min	$15.13
0374T	U1	GT	30 mins	$116.42	0373T	U1	GT	15 min	$58.21

0374T	U2	GT	30 mins	$77.94	0373T	U2	GT	15 min	$38.97
0374T	U3	GT	30 mins	$60.02	0373T	U3	GT	15 min	$30.01
0374T	U4	GT	30 mins	$40.60	0373T	U4	GT	15 min	$20.30
0374T	U5	GT	30 mins	$30.26	0373T	U5	GT	15 min	$15.13
0374T	U1	U7	30 mins	$148.18	0373T	U1	U7	15 min	$74.09
0374T	U2	U7	30 mins	$93.52	0373T	U2	U7	15 min	$46.76

Appendix F
Required Cover Sheet for Documentation Submission for PA

The below form must be printed out and submitted when providers are requesting preauthorization for assessment and treatment hours. Please complete all necessary fields and submit it as instructed.

Member's Name:________________________________Member's DOB:__________________Gender: M F

Diagnosis: ____

Diagnosed by Whom: ____

Date of Diagnosis:___________________Date of Letter of Medial Necessity: _____________________________

Is this member currently enrolled in school? Y N

Name of School: ____

Private and/or School related services (Circle service(s) and/or specify "other"):
Occupational Therapy Speech Therapy Physical Therapy Other:______________________________

Does this member have an IEP or IFSP? Y N
(If no, provide rationale for why there is no educational placement. Include family's plan with regard to having the member enrolled in school. Specify school/classroom information.)

____

____

____

Proposed Service Schedule		
Service and Time	Location	People Present
(Example) Direct Service: MWF 2 - 5pm	Home, Clinic	Client, Parent, RBT, BCBA (1x/wk)
(Example) Supervision: Wed 2-3pm	Home, Clinic	BCBA, Client
(Example) Parent Training: Every other Wed. from 2 – 3pm	Home	BCBA, Mother, Father

Authorization Date Range for Behavioral Assessment or Treatment:			
CPT Code:	# of hours/week	# of units/week	# of units/3 mths (13 wks) #of units/6 mths (26 wks)
0362T			
97151/97152 *Family of Codes			
97153/97154/97155 *Family of Codes			
97156			
97157			
97158			
0373T			

***Family of Codes: It is only necessary to enter one code from a bundle (family of codes) since the entire family is sent to the claim system. If more than one code from the same family is entered, only the actual code entered is sent to claims and not the complete family of codes.**

Note: The BACB requires ongoing supervision for a minimum of five percent of the hours that the RBT spends providing behavior-analytic services each calendar month.

Parent/Caregiver Training Goals: According to the BACB, goals must be specific and include baseline data, behavior that is expected to be demonstrated and mastery criteria, date introduced, date mastered, etc.

Parents/caregivers being present during the session is ***not*** sufficient for a parent/caregiver training goal. You are required to document and track 2 – 4 goals.

Assessment Results: Summarize findings from the initial and/or most recent behavioral assessment (e.g., FBA, VB-MAPP, etc.). Include visual representations (graphs, tables, grids) as appropriate.

Skill Acquisition Goals: These goals will be related to the core deficits of autism. Goals should be based on assessment performance or data from other providers. Baseline data and progress summary (if goal is in treatment) must be included. Visual representations (graphs, tables, grids) as appropriate.

Behavior Reduction Goals: Graphs are **required** and must include initial baseline, and graphic display of progress since the intervention was initiated. Interventions over long periods of time should be consolidated to weekly/monthly/etc. units of measurement or otherwise adjusted to be all inclusive of data collected.

Graph Requirements:

- All graphs must be legible with the x axis (horizontal) of the line graph labeled with session dates and the y axis (vertical) of the line graph providing the quantifiable measurement of the behavior that was recorded.
- The line graph should be in a ratio of 2:3 (i.e., If the y axis is 4 inches, the x axis should be 6 inches).
- Condition labels and legends should be utilized when more than one behavior is being graphed.
- Maximum number of three (3) behaviors or targets on a single graph.

Graph date format:

- The behavior assessment graph should include the member initials as well as the date in a month/day/year format and must have been conducted/dated no more than two (2) months prior to the Treatment Services PA request effective date.

Baseline data: Baseline is a data measurement that is collected prior to intervention that provides a starting point for comparison. This data must be measurable and indicate the member's present level of responding directly related to treatment plan goals.

Phase change lines or other indicators should be used to separate baseline data from intervention data as well as any changes to the intervention and/or varying levels of service.

School Plan: If ABA therapy is being provided in the school setting, the plan of care must outline a separate school plan that clearly defines the behaviors that are being targeted for reduction specific to this setting, lists behavior reduction goals and include line graphs that meet ASD policy guidelines. Skill acquisition goals should not be implemented in this setting as the primary objective should be reducing maladaptive behaviors that impede the member's ability to engage in academic tasks.

Checklist: ***Are the following attached?***

Diagnostic Evaluation

Letter of Medical Necessity

Plan of Care (Initial Treatment Plan or Progress Report) including the following:

- Brief background information including demographics, diagnostic history, medical history, living situation, school information (grade, IEP, services receiving, etc.), previous ABA services, current ABA services, etc.
- Current medications
- Parent/caregiver concerns
- Assessment procedures and results (graphs, tables, grids)
- Skill Acquisition Goals including baseline data, mastery criteria, progress summary
- Behavior Reduction Goals (if appropriate) including baseline data, operational definition/topography of behavior, treatment strategies, behavior reduction goal, progress summary, graphs
- Caregiver Training Goals including baseline data, mastery criteria, etc.
- Coordination of Care
- Transition Plan
- Discharge Criteria
- Crisis Plan

Supervising BCBA/BCBA-D Signature:____

Date: ____________________

APPENDIX G

Alliant Health Solutions - FFS Autism Therapy Services Prior Authorization

Overview

Providers may submit a request for Autism Therapy Services and attach supporting documentation via the Medical Review Portal. Go to the Georgia Web Portal at www.mmis.georgia.gov and log in using your assigned username and password. Once a request is submitted, the request data is added to the Alliant Health PA system and is available for review by Alliant Health staff. Once the decision has been rendered, Providers will receive a No-Reply email to notify them that a decision has been rendered. Additionally, should the prior authorization receive a second level review denial decision, the member will receive a notification letter from Alliant Health Solutions.

Autism Therapy Request Guidelines and Restrictions

- The PA type for Autism Therapy services is AU
- Providers must have COS code of 445 and a Specialty Code of 565 or 566
- Only Applied Behavioral Analysis (ABA) procedure codes may be entered on the request
- Providers submit one PA for assessment codes and one PA for treatment codes
- System validation prevents assessment codes and treatment codes to be entered on the same PA
- Requests must have an effective/start date equal to or greater than the request date
- All requests may be submitted with a procedure start date up to 60 days in the future
- If a member leaves an Autism provider's service, Alliant will **not** end-date the existing PA for that provider until an end-date is communicated to Alliant by the current provider. The notification may be submitted utilizing the "contact us" feature (please be sure to include the effective end date). This allows the current provider an opportunity to bill for services rendered. Once the current provider submits the end-date request, they must notify the caregiver and advise them to inform the new provider. For the denied PA to be re-reviewed, the new provider must submit a request to Alliant via the "Contact Us" feature.

  Please note that ALL PA's for ALL Medicaid Members MUST be requested prior to services being rendered. Any services not prior approved or provided prior to the PA Effective date will not be authorized or covered for reimbursement. Effective dates on existing PA's cannot be made retro or backdated under any circumstance or for any reason including Katie Beckett approvals with retroactive eligibility dates.

Autism Therapy PA Submission Instructions

- Refer to the following User Manuals which are located on GAMMIS at www.mmis.georgia.gov/portal (see following screenshot)
  - Select Provider Information
  - Select Provider Education
  - Select User Manuals
    - **FFS Autism User Guide** – this guide provides user instructions for submitting and viewing an Autism PA.
    - **Provider Workspace User Manual** – step by step instructions for utilizing the Web Portal Provider Workspace functionality

Reconsideration Request

From the *Medical Review Portal*, providers may submit a request for reconsideration of the decision rendered on an Autism PA. When a Reconsideration Request is processed, a no-reply email and a 'contact us' message are sent to the provider. The notifications inform the provider that the reconsideration was processed and to check the *Provider Workspace* for details.

Reconsideration Request Guidelines

- Reconsiderations are allowed when the PA has one or more procedure lines that are:
  - Approved but not for all units requested - requests must be submitted within **30** calendar days of the decision.
  - Peer consultant denied - requests must be submitted within **30** calendar days of the decision. **Please Note: Only one (1) reconsideration request submission per PA request following a peer denial can be submitted.**
  - Tech Denied but **NOT** Final Tech Denied - requests must be submitted within **10** calendar days of the decision.

- Providers are required to attach additional documentation to support the reconsideration request. It is not necessary to re-submit all information sent with the original request but only the information to support the request for reconsideration. If a technical denial is received, the provider has ten (10) calendar days from the date of the technical denial to electronically attach the missing information. **All missing information must be attached via the reconsideration link at the web portal. If the information is not received within the ten (10) calendar days, the provider will have to re-submit the entire PA request packet.** Instructions for electronically attaching supporting documentation can be accessed via the Georgia Web portal at www.mmis.georgia.gov under the Provider Information tab.

- If a technical denial is received, the provider has ten (10) calendar days from the date of the technical denial to electronically attach the missing information. **All missing information must be attached via the reconsideration link at the web portal. If the information is not received within the ten (10) calendar days, the provider will have to re-submit the entire PA request packet.** Instructions for electronically attaching supporting documentation

can be accessed via the Georgia Web portal at www.mmis.georgia.gov under the Provider Information tab.

✦ If a request for additional units is denied, the provider has the right to submit a request for "A Reconsideration of the PA Request" within thirty (30) calendar days of the peer denial. Only submit the necessary additional documentation supporting the request for reconsideration. There is no need to resubmit all information sent with the original request. Please electronically request a reconsideration review via the web portal and attach your supporting documentation at that time.

✦ Reconsideration of PA requests are not appropriate for PAs that have received technical denials. A technical denial means that there are missing documents, and the case cannot be referred to a peer consultant for final determination. If you receive an "initial technical denial", you have ten (10) calendar days to submit the required supporting documentation. If you do not submit within ten (10) calendar days, the PA should be resubmitted with all the required documentation.

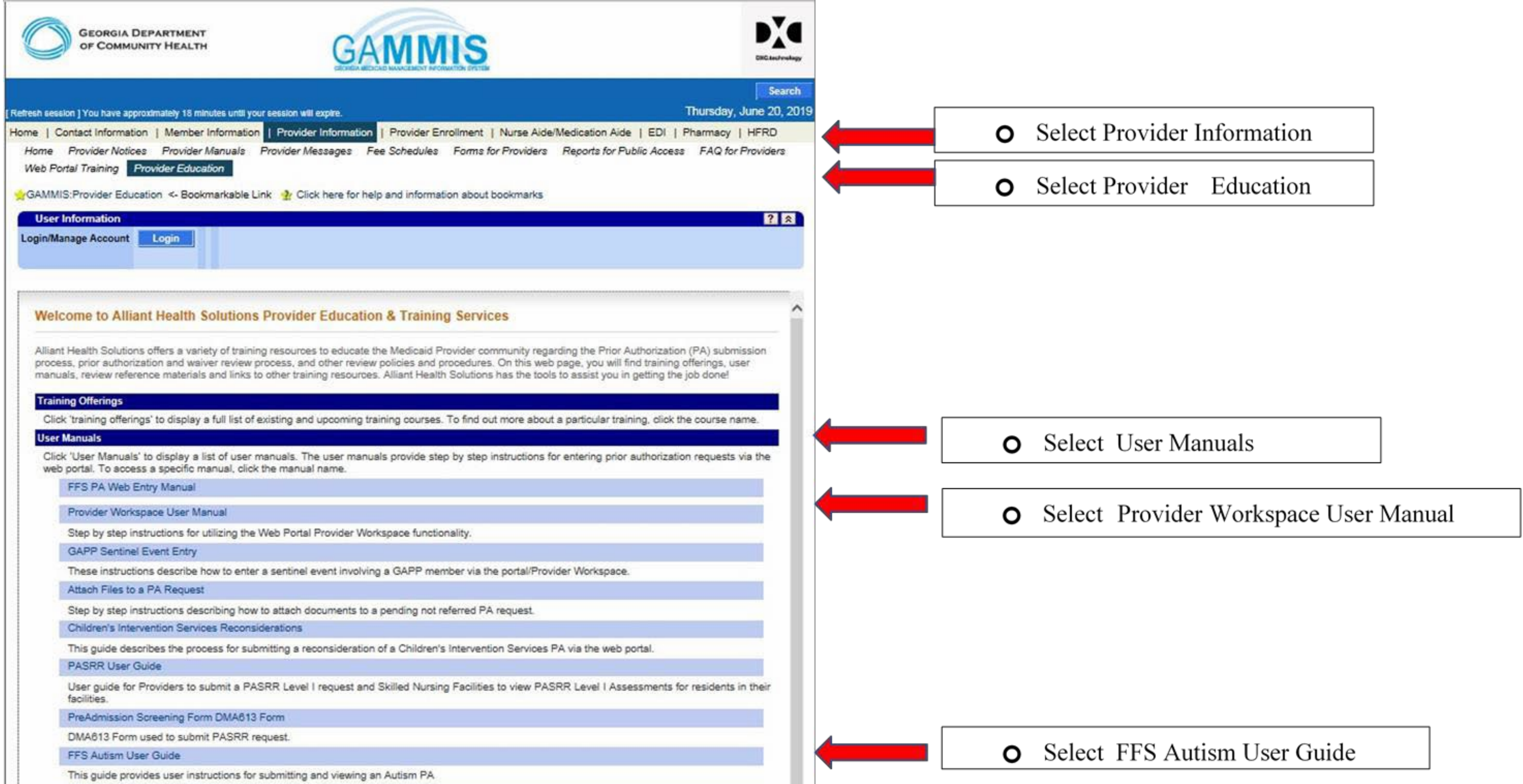
Change Requests

From the *Medical Review Portal,* providers may submit requests to change information on a PA; and may view change requests already submitted. Change requests are processed by Alliant reviewers and can be approved, denied, or referred. When a Change Request is processed, a no-reply email and a 'contact us' message are sent to the provider. The notifications inform the provider that a change request was processed and to check the Medical Review Portal for details. Providers can view the change request details, including the reviewer's decision comments, by searching for and opening the PA *Review Request* page.

Change Request Guidelines

Providers have the option to submit a "change request" via the web portal requesting a modification to a prior approval request; however, the following criteria must be met:

1. A significant change in treatment needs must be documented by submission of an updated and signed LMN/POC uploaded to the web portal. If additional units are requested, a treatment plan addendum that outlines the new goals with baseline data is required.
2. For a member whose name and Medicaid ID number has changed due to an adoption, the change request must also include the new Medicaid ID number. If there have been any paid claims against the PA, the GAMMIS will not accept changed made to the PA.
3. If a change in modality is requested, the units to be withdrawn (for substitution) must be specified.
4. This is applicable to PAs for which reconsideration has not been requested.



Effective May 28, 2020, the provider match criteria for Prior Authorization (PA) Type 'AU' (Autism) was removed from the MMIS. This change was completed to allow both affiliated and unaffiliated ASD providers access to all existing ASD PA's for members. Additionally, ASD providers can now render services in accordance with the date range specified not to exceed the maximum approved units. Providers will no longer be required to submit a Change Request via the Medical Review Portal for the remaining services when a member changes providers.

July 2020