



Autism Spectrum Disorder

Provider Education 2026

Partners in Healthcare

- Acentra Health is the Utilization Management/Quality Improvement Organization (UMQIO) for the South Carolina Department of Health and Human Services (SCDHHS) Healthy Connections Fee For Service Medicaid program. We have been providing services for SCDHHS since 2012.
- We bring together a deep collective of expertise across all facets with 30+ years of public sector health knowledge and experience.
- We currently provide:
 - Medical necessity reviews for multiple service types
 - Level of Care reviews
 - Pre-payment and post-payment reviews



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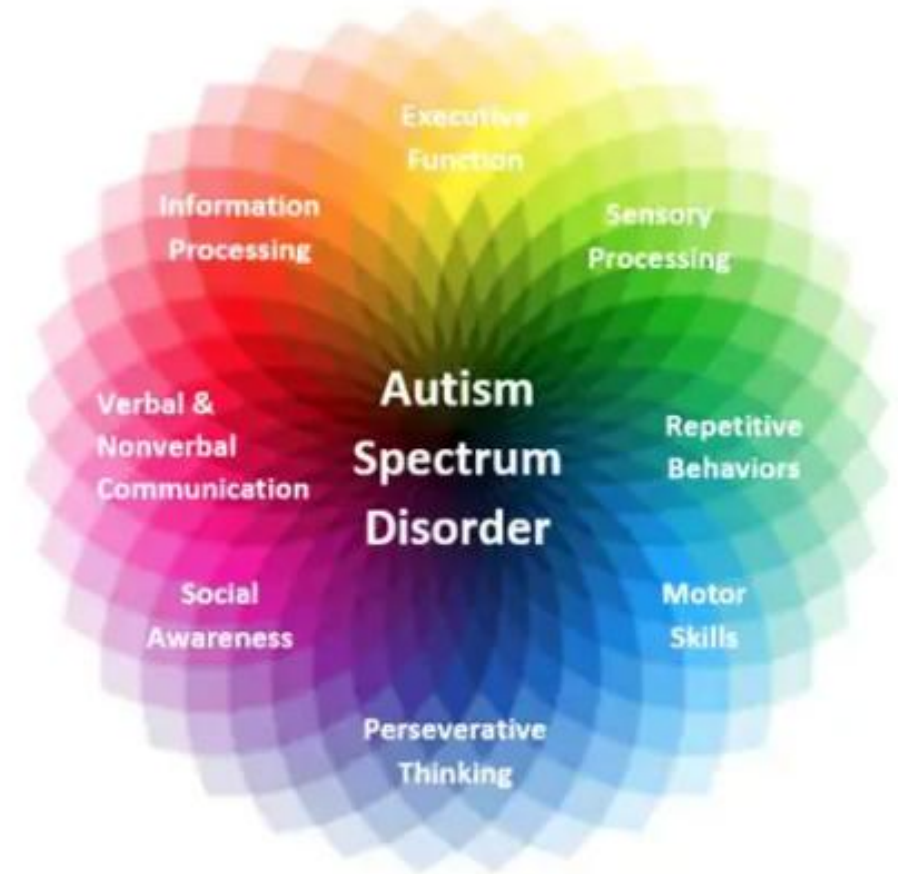
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Autism Spectrum Disorder

- Services to treat Autism Spectrum Disorder (ASD) are provided to eligible Medicaid beneficiaries ages 0 to 21. Services must aim to prevent the progression of ASD, prolong life, and promote the physical and mental health and efficacy of the individual.
- ASD Treatment Services include a variety of behavioral interventions. SCDHHS recognizes those interventions that are identified as evidence-based by nationally recognized research reviews, and those identified and supported with substantial scientific and clinical evidence.



Autism Spectrum Disorder

- In accordance with the EPSDT program, eligible beneficiaries at risk for the development of ASD are presumptively eligible for ABA service when the risk is determined thru IDEA Part C and/or the risk *is documented within the medical care home by a physician**.
- Covered Services must meet the following criteria:
 - Be medically necessary
 - Be provided to an eligible member by a participating provider
 - Be the most appropriate level of care consistent with professionally recognized standards of medical practice within the service area and applicable policies and procedures
 - Not be rendered for convenience, cosmetic or experimental purposes

*Policy updated 9/1/25

Autism Spectrum Disorder



Basic Requirements for Services

- Primary diagnosis of Autism Spectrum Disorder
- Age 0-21 and medically necessary
- Recommended by a licensed psychologist (PhD/PsyD), licensed physician (MD/DO), or Licensed Psycho-educational specialist (LPES) within his or her scope of practice
- Direct, synchronous assessment
 - Comprehensive Diagnostic Assessment for Initial Diagnosis
 - *Medical Care Home Autism Assessment*
 - *Presumptive Eligibility Determination Assessment*

Documenting Medical Necessity

Documenting Medical Necessity for initiating treatment

Medical necessity for ASD must be determined following a direct, synchronous assessment administer and completed by one of the following:

- Licensed physician (MD/DO)
- licensed psychologist (PhD/PsyD)
- Licensed psychoeducational specialist (LPES)

The clinician must document and attest that the assessment meets medical necessity criteria for ASD services under one of the following categories:

- Comprehensive Diagnostic Assessment for Initial Diagnosis of Autism Spectrum Disorder
- Medical Care Home Autism Assessment*
- Presumptive Eligibility Determination Assessment*

Comprehensive Diagnostic Assessment

Comprehensive diagnostic assessment/testing report must include the following for all beneficiaries:

- General member information (name, date of birth, date of assessment, date of report, reason for assessment etc.)
- Clinical Autism Interview w/ member and/or family/guardians
 - Medical & developmental history
 - Presenting symptoms, functional deficits, strengths, family support, barriers to care
 - History of exposure to physical, sexual and/or other trauma, antisocial behavior and/or substance abuse
 - Behavior rating scales
- Review of Psychological and/or psychiatric treatment history, including previous testing and assessment reports
 - **IMPORTANT* Clinician must document their request for all copies of any previous school-based psychoeducational evaluations, individualized education plans, behavioral intervention plans, or other plans outlining school accommodations. Results from these evaluations must be included in the diagnostic assessment**
- ASD diagnosis AND severity level
 - Assessments conducted prior to member's fourth birthday must reflect a presumptive diagnosis
- Structured observations supported by one of the following validated assessment tools
 - Autism Diagnostic Interview (ADI-R)
 - Autism Diagnostic Observation Schedule (ADOS)
 - Childhood Autism Rating Scale (CARS)
- A clinically appropriate, standardized, cognitive or developmental measure per the clinician's scope of practice that addresses any role of global developmental disability or intellectual disability in the clinical presentation.
- Recommendations for additional services, support or treatment
- Name of the psychologist, Licensed Psycho-educational specialist, or physician, title, signature and date

Medical Care Home Autism Assessment

Effective 9/1/2025

The determination of medical necessity and full eligibility for ASD services may be made through the focused medical assessment by a physician with the child's medical care home. This assessment is valid when the physician is confirming medical necessity of ASD services for a member with:

- a pre-existing academic designation of autism spectrum disorder,
- a pre-existing DSM supported diagnosis of ASD completed out of state,
- for an initial medical eligibility determination for a member between 18 and 36 months of age who is medically uncomplicated and has unequivocal symptoms of autism spectrum disorder.

Medical Care Home Autism Assessment Cont.

The clinical report should include all the following:

- Detailed clinical Interview clarifying the member is medically uncomplicated
- Documented physical exam.
- A standardized developmental screening or assessment using the most updated version
 - Ages and Stages Questionnaire (ASQ)
 - Parents' Evaluation of Developmental Status – revised (PEDS-R)
 - Child Development Inventory (CDI)
- An “at-risk” score on a validated primary autism screening tool
 - Modified Checklist for Autism in Toddlers (MCHAT)
 - Communication and Symbolic Behavior Scales Developmental Profile – Infant/Toddler Checklist (CSBS-ITC)
 - Survey of Well-Being of Young Children: Parent's Observations of Social Interactions (SWYC:POSI)
- Structured Behavioral observations supported by one of the following:
 - Rapid Interactive Screening Test for Autism in Toddlers (RITA-T) score of 18 or higher
 - Screening Tool for Autism in Toddlers and Young Children (STAT) score of 3.0 or higher

Medical Care Home Autism Assessment Cont.

Cont.

- A diagnosis from the current DSM, including severity levels
- Recommendation for additional services, support or treatment based on medical necessity and standards of care
 - Referral to the States IDEA Part C program (required)
 - Referral to the member's school district to assess for school-based services (required)
 - Referral to SC Office of Intellectual and Developmental Disabilities (OIDD) (required)
 - Referral to Pediatric Audiology services or documentation of audiology evaluation(required)
 - Referral to Pediatric Genetics or documentation of a parent/caregiver's deferral of this recommendation
 - Referral to clinically applicable rehabilitative therapies that the child is not already receiving (PT/OT/ST)
 - Referral for applied behavioral analysis therapy, or documentation of a parent/caregiver's deferral of this recommendation
- The licensed physicians name, specialty, professional title, signature/credentials and date
- Completion of the *Autism Diagnostic Tool for Physician Use in the Medical Care Home*

Presumptive Eligibility Assessment

Medicaid beneficiaries at-risk for the development of ASD may be eligible for applied behavior analysis (ABA) services until their 6th birthday while awaiting a comprehensive diagnostic assessment (CDA). Presumptive eligibility for ABA services is considered valid when the member has been determined to be presumptively eligible for ABA therapy through South Carolina's IDEA Part C program or when an approved physician with verified training and certification in the administration of a validated secondary autism screener, documents the following in their clinical note:

- Required clinical criteria has been met
 - member between 18 and 36 months at time of the assessment
 - member has received an “At-risk” score on a validated primary autism screener
 - RITA-T score ≥ 12
 - STAT score ≥ 2.0
- Referrals to support medical standard of care and care coordination
 - Referral to the States IDEA Part C program (required)
 - Referral to the member's school district to assess for school-based services if member is 30 months of age or older(required)
 - Referral to SC Office of Intellectual and Developmental Disabilities (OIDD) (required)
 - Referral to Pediatric Audiology services or documentation of audiology evaluation(required)
 - Referral to a regional Developmental Evaluation Center (DEC) or other practice capable of completing a comprehensive diagnostic assessment (CDA) (required)
 - Referral to clinically applicable rehabilitative therapies that the child is not already receiving (PT/OT/ST)
 - Referral for applied behavioral analysis therapy, or documentation of a parent/caregiver's deferral of this recommendation

Presumptive Eligibility Assessment Cont.

- Clear documentation that counseling was provided to the parent/caregiver
 - Presumptive eligibility is not a medical diagnosis but an agreement to support ABA therapy due to a child's documented risk for development of ASD
 - Presumptive eligibility does not automatically extend or affect eligibility for state specific EIS, school-based services through the DOE or OIDD. Each entity maintains its own eligibility process.
 - To ensure ongoing eligibility a formal assessment must be completed prior to the child's 6th birthday
- The licensed physicians name, specialty, professional title, signature/credentials and date
- Completion of the *Presumptive Eligibility Tool for Physician Use in the Medical Care Home* form

Prior Authorization

Tips for Submission

Tips for successful submission to reduce total turnaround time and PA discrepancies

Eligibility	Documentation	Timeliness	HIPAA
Check member Eligibility - Providers are responsible for checking eligibility and plan benefits <u>BEFORE</u> rendering services and requesting PA. - Managed Care Organizations are responsible for authorizations for beneficiaries enrolled in MCOs	Only relevant records - Send only information relevant to the request being submitted (<u>More is not better</u>). - Specifics can be found in the trainings for each service type. - Review request should not be submitted without documentation attached.	Submit timely - Request for authorizations should be submitted prior to the service in almost all cases - Retrospective requests should only be submitted for beneficiaries who where not eligible for care at the time of service.	Check records - Please check records before submitting to ensure ONLY those records for the member needing services are attached. - Attaching clinicals belonging to another member is a HIPAA violation.

Codes Requiring Prior Authorization

SCREENING AND DIAGNOSTIC ASSESSMENT SERVICES				
SERVICE NAME	PROC CODE	MOD	DESCRIPTION	FREQUENCY LIMITS
Behavior Identification Assessment	97151		BCBA-D BCBA BCaBA *via interactive video/audio telecom	32 units annually
Behavior Identification supporting Assessment	97152		BCBA-D BCBA BCaBA RBT* -(intended for RBT under direction of physician or other qualified health care professional, face-to-face with patient)	21 units per day (up to 84 units per week)
Behavior Identification Supporting Assessment—2 or more Technicians	0362T		BCBA-D BCBA BCaBA RBT* (Must be billed by BCBA-D, BCBA, or BCaBA who is on site and directing treatment; service is face-to-face with patient)	16 units per day (claim is based on total time elapsed, not total time per each technician)

*no authorization required

Codes Requiring Prior Authorization

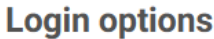
ASD TREATMENT SERVICES				
Adaptive Behavior Treatment by Protocol	97153		BCBA-D BCBA BCaBA RBT*	160 units per week (in any combination)
Group Adaptive Behavior Treatment by Protocol	97154		BCBA-D BCBA BCaBA RBT*	2 – 6 patients, up to 6 hours a day
Adaptive Behavior Treatment with Protocol Modification	97155	GT	BCBA-D BCBA BCaBA RBT* GT = Via interactive video/audio Telecommunication*	To be rendered at the rate of 10% of weekly therapy hours (97153), up to 64 units per month GT *requires prior authorization
Adaptive Behavior Treatment with Protocol Modification —2 or more technicians	0373T		BCBA-D BCBA BCaBA RBT* (Must be billed by BCBA-D, BCBA, or BCaBA who is on site and administering treatment; service is face-to-face with patient)	32 units per day (claim is based on total time elapsed, not total time per each technician)

ASD Treatment Services					
Family Adaptive Behavior Treatment Guidance	97156	GT	BCBA-D BCBA BCaBA GT = Via interactive video/audio telecommunication	1 unit = 15 minutes	96 units annually (up to 24 hours a year)
Multi-Family Group Adaptive Behavioral Treatment guidance	97157		BCBA-D BCBA BCaBA (service is without patient present)	1 unit = 15 minutes	16 units per day Ratio: 1 provider:(2-6 caregivers and/or sets of caregivers, not to exceed 8 total participants)
Group Adaptive Behavior Treatment by Protocol	97158		BCBA-D BCBA BCaBA RBT*	1 unit = 15 minutes	2-6 patients, up to 6 hours per day

Non- ABA Treatment Services

- Non-ABA ASD treatment services can only be rendered by a Licensed independent Practitioner after receiving prior authorization.
- These requests will be submitted under the Mental Health Service Type in Atrezzo (not ASD)

SERVICE NAME	PROC CODE	Modifier	Service Provider	Units	Frequency Limits
Non-ABA Treatment Services	H2019		Licensed Psychologist Licensed Psychoeducational Specialist Licensed Independent Social Worker-Clinical Practice Licensed Marriage and Family Therapist Licensed Professional Counselor	1 unit = 15 minutes	4 units per week



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Authorization Types



☐ Prior Authorization

Should always be submitted on or before the service begins

☐ Retrospective Authorization “Retro”

Needed when services were performed **before** the member was eligible for Medicaid and the member has since been granted retrospective eligibility covering the date of service.

- A Retro case is NOT one that is submitted late for any reason other than eligibility.
- Untimely requests will be administratively denied.

Requesting 97155 with Telehealth

- 97155 is intended to be delivered in person. Effective 7/1/2026, up to 25% of the authorized units may be approved for use with a GT modifier on a case-by-case basis. Active authorizations will not be modified. *Requests for GT modifier will need to be requested on the next authorization period.

Create case
Step 4

Additional providers
Step 5

Service details
Step 6

Diagnoses
Step 7

Requests
Step 8

Questionnaires
Step 9

Attachments
Step 10

Communications
Step 11

Requests/Request 01/Procedures

Code type (Required)

CPT

Search

Search by code or description

Request 01

Un-Submitted 4/0

97155 Un-Submitted

07/01/2026 - 12/27/2026 48 / 0

97153 Un-Submitted

07/01/2026 - 12/27/2026 128 / 0

97155 Un-Submitted

07/01/2026 - 12/27/2026 16 / 0

97156 Un-Submitted

07/01/2026 - 12/27/2026 96 / 0

97155

ADAPT BEHAVIOR TX PHYS/QHP

Modifier

GT

Unit qualifier

Select One

Requested

Requested start date (Required)

07/01/2026

Requested end date (Required)

12/27/2026

Requested duration (Required)

180

Requested quantity (Required)

16

Requested frequency

Monthly

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Initial treatment requests

Initial Treatment Request must include:

- Comprehensive diagnostic assessment/testing report and/or required physician documentation of a Medical Care Home based assessment **or** Presumptive Eligibility for ABA Services
- Behavior Identification Assessment (BIA)
- Functional Behavior Assessment (FBA) when addressing maladaptive behavior, requesting more than 15 hours of 97153, or services delivered in a school-based setting.
- Copies of current treatment plans from all providers on the member's rehabilitative therapy team (ST/OT and PT)
- Individual Plan of Care (IPOC)
- If ABA services are requested to be delivered in a school place of service, submission of ALL the following are required: IEP with ASD designation, FBA and BIP

Continued treatment request

- Continued medical necessity for ABA therapy must be demonstrated by thorough explanation of the following:
 - Member's progress towards all the following:
 - Minimizing or eliminated targeted problem behaviors(s); AND
 - Reducing targeted area(s) of functional deficit or delay (as demonstrated by assessment instrument scores over time) OR
 - Acquiring new communication, social, self-help, or other adaptive behavioral skills in the target area(s) of deficit
 - Reaching the transition and fade criteria outlined in the initial request
 - If the member has failed to demonstrate progress in the above areas, medical necessity for continuation of ABA services can be addressed through a description of the list of variables that impacted the member's response to their ABA therapy treatment services, and a detailed description of how those variables prevented the member's anticipated progress towards their IPOC goals and objectives since the member's immediately preceding authorization period.
 - In addition to the narrative the most recent IPOC and progress summary
 - Updated educational and behavioral assessments from the member's school
 - Updated treatment plans from the member's ST/OT/PT

Continued treatment requests

- **Supporting clinical documentation** may include but is not limited to:
 - Barriers to progress
 - Lack of Progress
 - Changes in treatment protocols
 - Transitions with implication for continuity of care
 - Issues of member health & safety
 - Sophistication or complexity of treatment protocols
 - Family dynamics or community environment changes

Annual Treatment Review

- Documentation for an annual review must include the submission of all the following:
- Thorough explanation of the member's progress toward all the following:
 - Minimizing or eliminating targeted problem behaviors (s); AND
 - Reducing targeted area(s) of functional deficit or delay (as demonstrated by assessment instrument scores over time); OR
 - Acquiring new communication, social, self-help, or other adaptive behavioral skills in the targeted area(s) of deficit
 - If the member has failed to demonstrate progress in the above areas, medical necessity for continuation of ABA services can be addressed through a description of the list of variables that impacted the member's response to their ABA therapy treatment services and a detailed description of how those variables prevented the member's anticipated progress towards their IPOC goals and objectives since the member's immediately preceding authorization period.
 - Progress toward member's transition and fade criteria
- All Progress Summaries
- Member's update BIA
- Member's updated FBA as outlined in Section 8 of the provider manual
- Updated IPOC
- If ABA services are requested to be delivered in a school place of service, submission of ALL the following are required: IEP with ASD designation, FBA and BIP

Additional Information

Tips for success



Please ensure your documentation includes the following information to reduce the potential for pends:

- whether the Behavior Analyst has coordinated with all other allied health services and has obtained specific information on types of services provided AND number of hours per week for each type of service AND behaviors or deficits targeted the member
- whether the member attends school or preschool or EIP (full or partial)
- whether the Behavior Analyst has coordinated with school or an early intervention program and has obtained specific information on types of services provided AND number of hours per week for each type of service AND behaviors or deficits targeted.

Individual Plan of Care

The IPOC is a comprehensive plan of care outlining the service delivery that will address the specific strengths and needs of the member. It must be individualized and specify problems to be addressed, goals and strengths. The IPOC should be reviewed as part of the regular progress summary and updated, as necessary. A new signature is required for every change. A new IPOC must be developed every 12 months.



IPOC must include:

- Member's strengths, needs, abilities, & preferences
- Goals & objectives of treatment, tied into the child's assessment & evaluation results
- Outline to address the assessed needs of member, including, but not limited to specific description of the recommended amount, type, frequency, setting and duration of ASD treatment services needed
- Specific treatment activities or interventions
- Amount/ type of parent/caregiver participation if applicable
- The date of each completed progress summary and annual re-development
- Signature, title and date of multidisciplinary team members including the parent/caregiver
- **Unsigned IPOCs will not be accepted.**

Progress Summary



Progress Summary must include:

- Specific objective(s) from the IPOC that were a focus of treatment
- Specific treatment activities or interventions
- Goals that have been met
- Cumulative graphs of goals and objectives demonstrating progress or areas of concern
- Explanation of any delayed progress to include barriers toward IPOC goals
- Explanation of any failure to provide the recommended services and their frequency
- Amount & type of parent/caregiver participation, if applicable
- Summary of treatment plan for the upcoming treatment period, tied into objectives and goals of the IPOC
- **Signature, title and date of multidisciplinary team members, including caregiver/parent**

Behavior Identification Assessment (BIA)

The Behavior Identification Assessment (*97151) must be administered by a BCBA-D, BCBA or BCaBA, face-to face with the patient and caregiver(s). The assessment must include:

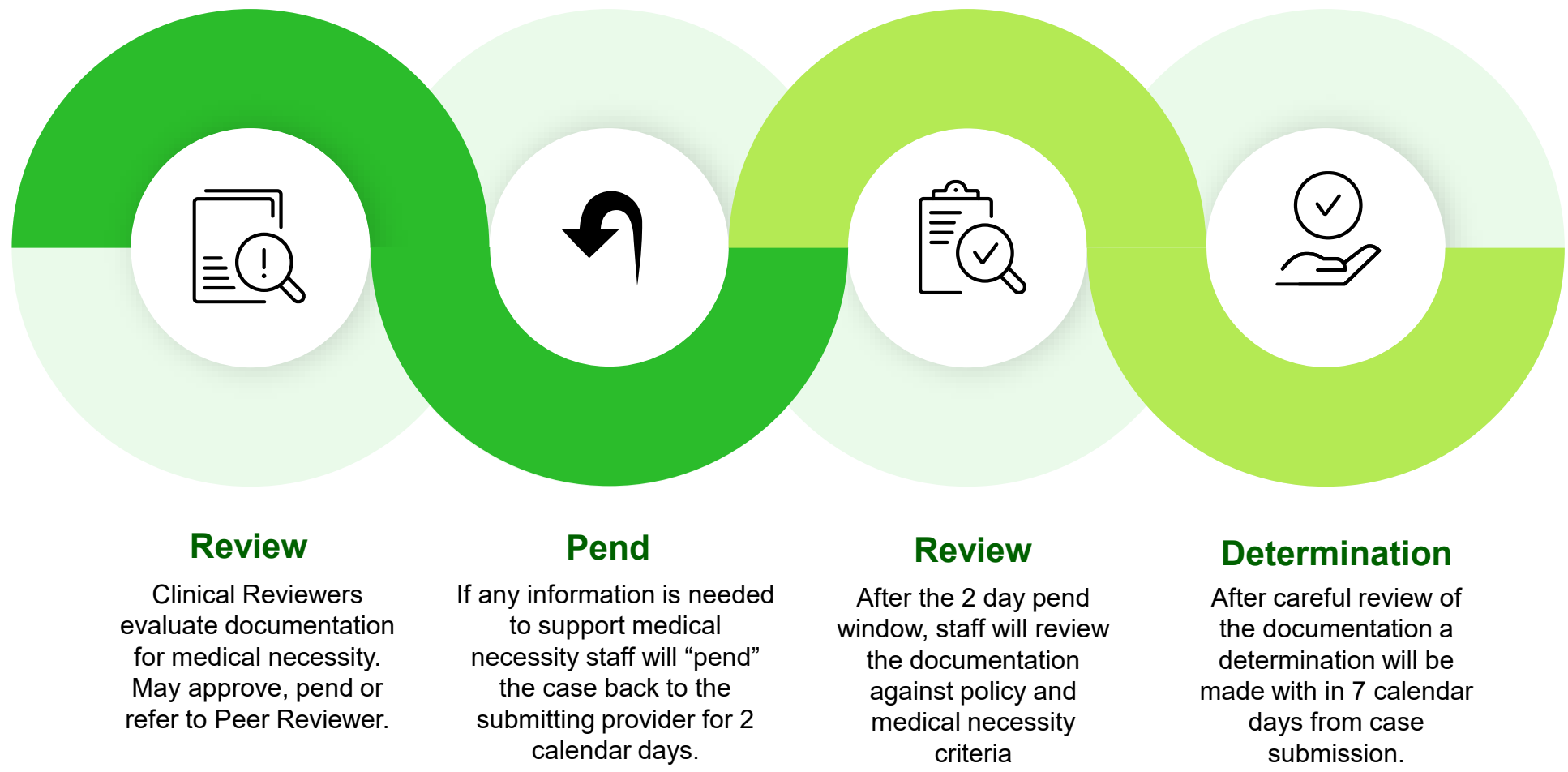
- Clinical Interview with caregiver seeing ABA treatment; and
- Direct patient observation in patient's natural environment and in ALL settings where ABA treatment is being requested (*Home and/or Clinic); and
- Vineland Adaptive Behavior Scales, all domains, including maladaptive behavior domain; and
- Questions about Behavioral Function (QABF) administered to the caregiver seeking ABA treatment; and
- At least 1 of the following skills or functional assessments:
 - ✓ Pervasive Developmental Disorder Behavioral Inventory
 - ✓ Social Responsiveness Scale (SRS)
 - ✓ Verbal Behavior Milestones Assessment & Placement Program (VB-MAPP), must include the Barriers Assessment AND the Transitions Assessment
 - ✓ Assessment of Functional Living Skills (AFLS)
 - ✓ Essentials for Living (EFL)
 - ✓ Assessment for Basic Language & Learning Skills (ABLLS-R)
 - ✓ Promoting the Emergence of Advanced Knowledge- Comprehensive Assessment (PEAK)

* 97151 does not require a prior authorization

BIA continued

- A functional Behavior Assessment is REQUIRED as part of the BIA, to support prior authorization requests for ANY of the following:
 - Treatment for > 15 hours per week of 97153
 - Treatment for any goals related to maladaptive or challenging behavior
 - Treatment for any goals planned to be delivered in a school-based setting
- The FBA must include ALL the following additional measures:
 - Interview-Informed Synthesized Contingency Analysis (IISCA); and
 - Functional Assessment Screening Tool (FAST) with caregiver reporting behavioral challenges; and
 - PEAK Autism Symptoms and Behavioral Observation Summary (PAS-BOS); and
 - Direct observation of child in EVERY service location where ABA treatment is being requested with ABC Data, Scatterplot recording, Event recording and Standard Celeration Chart (SCC).
 - Crisis Plan

Review Process



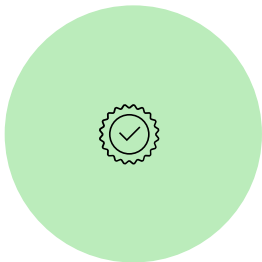
Review Determinations and Steps

Acentra Health uses the following determinations to complete a request. Cases submitted without clinical information will be rejected.



Administrative Denial

Occurs when the request does not meet basic Medicaid policy or requirements (untimely, failure to respond to pends, failure to submit required documentation)



Approval

Occurs when the documentation submitted supports Medicaid policy and medical necessity for the requested service/units.



Partial Approval

Occurs when the documentation submitted supports some, but not all the services/units requested.



Denial

Occurs when the documentation submitted does not support the full weight of the requested services/units



Reconsideration

May be requested by a provider or member when a service has been denied by a peer reviewer as not meeting medical necessity or standards of care.



Appeal

May be requested by a provider or member when a previously denied service has been thru the reconsideration process and the decision was upheld

Reconsiderations



- May be submitted within 30 days of the **clinical** denial date
 - This is your opportunity to provide more detailed clinicals
- May be submitted via
 - Web portal *preferred
 - Fax
- A clinical reviewer will review any additional information submitted. If unable to meet medical necessity, the case will be referred to the peer reviewer (BCBA-D).
- A peer reviewer – a different BCBA-D from the one who originally reviewed the case - will look at the case and any new information submitted to support the reconsideration.
- The peer reviewer may
 - Uphold original decision (no change made).
 - Overturn the original decision (approve the case).
- If original decision is upheld, provider may appeal the decision to SCDHHS.

Appeals

Conducted by SCDHHS

If a reconsideration is upheld, an appeal may be requested through SCDHHS. Instructions will be included in the reconsideration determination letter.

SCDHHS will review the provider's request and conduct an internal review or Fair Hearing.

Beneficiaries may request an appeal within 30 calendar days from the reconsideration determination notice:

online at www.scdhhs.gov/appeals,

Fax 803 255 8206

Email appeals@scdhhs.gov

Mail Office of Appeals and Hearings

PO BOX 8206

Columbia, SC 29202



Resources and Education

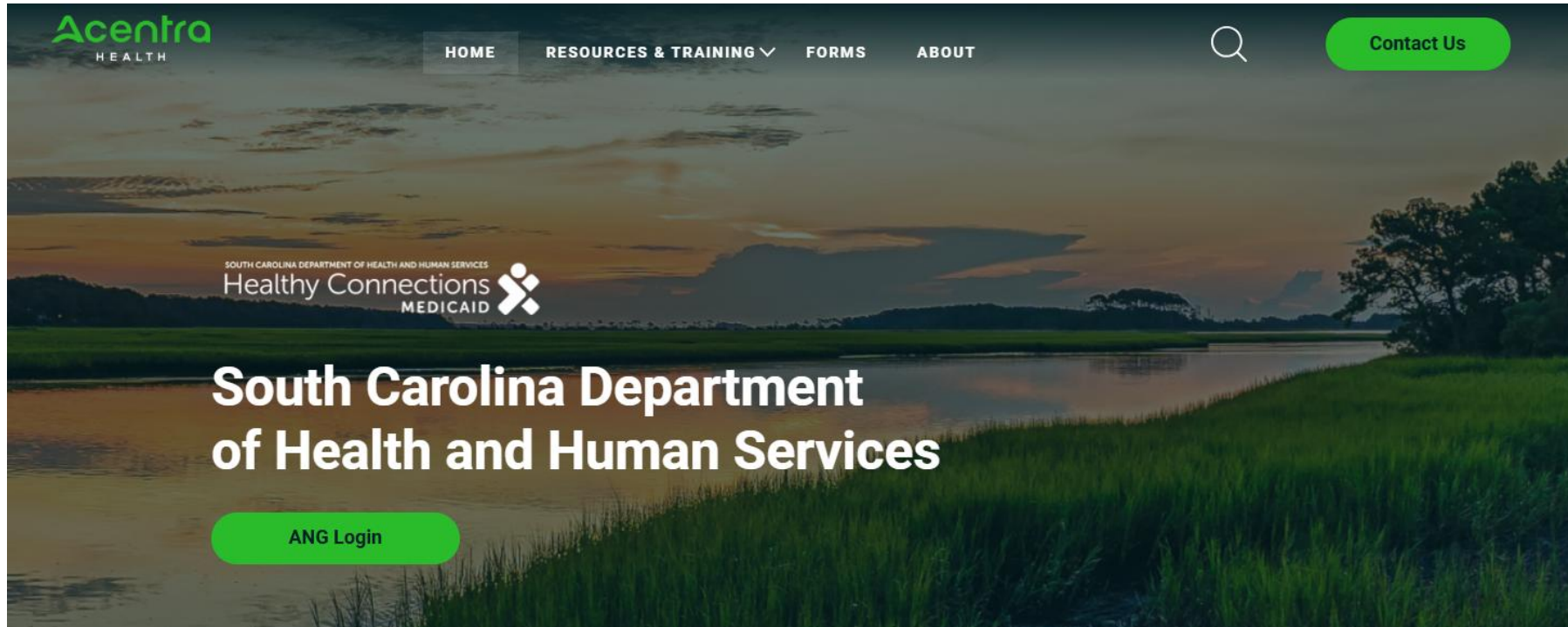
[SCDHHS Autism Spectrum Disorder \(ASD\) Services Provider Manual](#)

[Provider Training Resources | SCDHHS](#)

[SC Acentra Health website](#)

Acentra Health Customer Service 1-855-326-5219

scproviderissues@acentra.com generic questions please, do not include PHI





Accelerating
Better Outcomes