



Connecticut Medical Assistance Program
Policy Transmittal 2015-33

Provider Bulletin 2015-69
October 2015

Roderick L. Bremby, Commissioner

Effective Date: January 1, 2015

Contact: William Halsey @ (860) 424-5077

TO: Medical Clinics, Rehabilitation Clinics and Board Certified Behavior Analysts (BCBAs)
RE: Autism Spectrum Disorder (ASD) Evaluation and Treatment Services Provided by Medical Clinics, Rehabilitation Clinics and Board Certified Behavior Analysts

The purpose of this policy transmittal is: (1) to inform medical and rehabilitation clinics that they were inadvertently omitted from the distribution list of PB 2014-99 when it was sent out in December 2014 and (2) to share that bulletin with Board Certified Behavior Analysts (BCBAs) who began enrollment after the original bulletin was distributed. What follows is the verbatim text of that transmittal except that when verb tense needed to be changed the old language is bracketed [] and the new language italicized. Also, the Table at the end has been modified to include the medical and rehabilitation clinics.

*Note that the reimbursement rate for medical clinics and rehabilitation centers is identical to the rate paid to behavioral health clinics. The reimbursement for Autism Specialists and Autism Specialist Groups is listed in the column labeled **BCBA** on the attachment.*

The purpose of this policy transmittal is to inform Medicaid enrolled providers that effective **January 1, 2015**, the Department *expanded* [will expand] its coverage of Autism Spectrum Disorder (ASD) evaluation and treatment services for Medicaid enrolled members (HUSKY A, C, or D) under the age of 21 for whom ASD services are medically necessary.

The Department is adopting new regulations governing payment for ASD services provided to Medicaid members under age twenty-one. The Department proposes to amend the Regulations of Connecticut State Agencies adding new sections 17b-262-1051 to 17b-262-1065, inclusive. Pursuant to section 17b-10 of the Connecticut General Statutes, the Department plans to implement the proposed regulation in draft form as a binding operational policy, effective January 1, 2015. Please review the Operational Policy carefully. **If there is an inconsistency between this Policy Transmittal and the Operational Policy (in the form of the proposed regulations), the Operational Policy takes precedence, until the regulations are formally adopted (and will then take precedence).** To access the Operational Policy, go to www.ct.gov/dss, then go to "Publications," then "Policies and Regulations," then "Notices of Intent, Operational Policies, and

Proposed Regulations," then select the operational policy concerning ASD.

ELIGIBLE MEDICAID MEMBERS

Individuals eligible for ASD evaluation and treatment services must be enrolled in Medicaid (HUSKY A, C, or D) and under the age of 21.

In order for an individual to receive treatment services, he or she must have a comprehensive diagnostic evaluation that recommends ASD services based on an ASD diagnosis consistent with the Diagnostic and Statistical Manual for Mental Disorder (DSM 5) definition of Autism Spectrum Disorder.

EVALUATION SERVICES

Medical/Physical Evaluation: A medical/physical examination is necessary prior to receipt of services to treat ASD. The evaluation will review the individual's overall medical health, hearing, speech, and vision, as appropriate, and should include a validated ASD screening tool. The evaluation is intended to rule out medical or behavioral conditions that may co-occur with ASD or be misinterpreted as ASD. These evaluations are provided by a physician, advanced practice registered nurse (APRN)/nurse practitioner, or physician assistant. These evaluations are billed using existing covered evaluation and management procedure codes (e.g., 99201-99205, 99211-99215, 99241-99245 or 99251-99255) available to the appropriate provider.

Comprehensive Diagnostic Evaluation: This evaluation is a neurodevelopmental review of cognitive, behavioral, emotional, adaptive, and social functioning, and should use validated evaluation tools in order to diagnose and recommend general ASD treatment interventions and issue a comprehensive diagnostic evaluation including an evaluation report. The comprehensive diagnostic evaluation must be performed by a licensed practitioner (e.g. psychiatrist, neurologist, pediatrician including a developmental pediatrician, psychologist, licensed clinical social worker) working within his/her scope of practice and who is qualified and experienced in providing ASD evaluation services as defined in section 17b-262-1056 of the proposed regulation.

If a member had a previously established ASD diagnosis by a qualified and experienced ASD evaluator, as described above, the comprehensive diagnostic evaluation need not be repeated, but must be confirmed by a licensed practitioner within the previous twelve months. The comprehensive diagnostic evaluation must include a review of the most recent medical evaluation. The most recent medical evaluation must have been completed in the last twelve months. If the practitioner diagnoses the individual with ASD based on the comprehensive diagnostic evaluation, the practitioner should refer the individual for a behavior assessment.

Behavior Assessment: A behavior assessment is a clinical compilation of observational data, behavior rating scales, and reports from various sources (e.g. schools, family, pediatricians, etc.) designed to identify the individual's current strengths and needs across developmental and behavior domains. It assesses which autism treatment services would be most appropriate for the individual's care. Validated assessment tools or instruments must be utilized and can include direct observational assessment, observation, record review, data collection, and analysis. The behavior assessment must include the current level of functioning using one or more validated data collection instruments or tools. The assessment must be performed or updated not more than six months before treatment services are requested.

Plan of Care: The practitioner who conducted the behavior assessment will develop a detailed Plan of Care specifically tailored to each individual that must include, but is not limited, to the following elements: a) measurable goals and expected outcomes if treatment services are effective; b) specific description of the recommended amount, type, frequency, setting, and duration of ASD treatment services needed to best meet the needs of the member; and c) amount and type of parent/care giver participation required to maximize success.

ASD TREATMENT SERVICES

ASD treatment services include (A) services identified as evidence-based by nationally recognized research reviews, (B) services identified as evidence-based by other nationally recognized substantial scientific and clinical evidence or (C) any other intervention supported by credible scientific or clinical evidence, as appropriate to each individual. ASD treatment services include a variety of behavioral interventions that meet the criteria in one or more of (A), (B) or (C) above, such as evidence-based Applied Behavior Analysis interventions that meet one or more of those criteria. The ASD treatment intervention services must be done under the supervision of a qualified licensed practitioner working within his/her scope of practice or

by a qualified Board Certified Behavior Analyst (BCBA) working within his/her scope of practice. The supervising practitioner is responsible for all of the care provided to the member and for supervising the technician and any other support staff.

Caregiver Participation in ASD Treatment Services

A caregiver (e.g. parent, guardian, family member, babysitter, child care worker, etc.) shall participate in treatment sessions in a manner specified in the behavioral plan of care that is sufficient to maximize the quality and clinical effectiveness of the services, as tailored to the needs of each member. Specifically, the caregiver shall participate in at least 50% of all treatment sessions, which may be reduced if appropriate for a member's unique circumstances in a manner that continues to ensure the medical necessity, quality and clinical effectiveness of the services, as documented and explained in the plan of care. The caregiver's participation in ASD treatment sessions includes training for the caregiver to reinforce ASD treatment services in a clinically effective manner.

The performing provider shall document the caregiver's participation in ASD treatment sessions in the treatment notes, including the caregiver's name and relationship to the member, date, time, extent and type of participation.

Presence or Availability of Caregiver for ASD Treatment Services

In order to ensure ASD treatment services are Medicaid coverable services and do not include non-coverable services such as child care, respite, or related services, a caregiver shall be present or available in the setting where service are being provided at all times in order to care for members under the age of eighteen, even when the caregiver is not directly participating in the services.

PROVIDER QUALIFICATIONS AND ENROLLMENT

Practitioners who provide the comprehensive diagnostic evaluation, behavior assessment, and plan of care, and who supervise the treatment intervention services must be enrolled in the Connecticut Medical Assistance Program either as a performing provider associated to a billing provider (such as a group practice or a clinic) or as an individual billing provider. Providers must work within their scope of practice, and have specific experience, training, and specialization in ASD services.

Starting January 1, 2015, all BCBA's [must] *were required* to be credentialed in writing by the Department of Development Services (DDS) as meeting the applicable qualifications described below. Starting January 1, 2016, all licensed practitioners who provide the comprehensive diagnostic evaluation,

behavior assessment, plan of care, and treatment services must also be credentialed in writing by DDS. All licensed practitioners performing behavior assessments and treatment services must still comply with all qualification requirements described below beginning January 1, 2015, and the Department or the ASO may request documentation that the provider meets those qualifications.

Providers of Comprehensive Diagnostic Evaluations

Qualified providers of comprehensive diagnostic evaluations must comply with section 17b-262-1056(c) of the proposed regulation. In addition, starting January 1, 2016, all providers of comprehensive diagnostic evaluations must also meet the qualifications set forth in section 17a-262-1057(d) of the proposed regulation.

Providers of Behavior Assessments and ASD Treatment Services

Qualified providers of the behavior assessment and ASD treatment services must possess specialized training, experience or expertise in ASD. Qualified providers include:

- Physicians;
- Advanced Practice Registered Nurses;
- Physician Assistants;
- Licensed Psychologists;
- Licensed Clinical Social Workers;
- Licensed Marital and Family Therapists;
- Licensed Professional Counselors; and
- Board Certified Behavior Analysts.

Those providers must meet the requirements set forth in section 17a-262-1057(d) of the regulation. Specifically, at least:

1. Training: 18 hours of continuing education in ASD services in the last three years, which may include training approved for maintenance of certification for BCBAs, or any appropriate training approved for license maintenance for any category of licensed practitioners listed immediately above; and
2. Professional Experience: Two years of full-time equivalent work experience in treating individuals with ASD beginning after the individual graduated with a degree that made the individual eligible for applicable licensure or certification or the date of actual certification, whichever is later; and
3. ASD Education or Supervised Professional Experience: All licensed practitioners and BCBAs shall meet the requirements of either subparagraph (A) or subparagraph (B) below:
 - A. ASD Education: Passing grades in not less than 15 credit hours or the equivalent of graduate-level courses from an accredited college or university which, include significant content in all of the following: ASD treatment, diagnosis and assessment;

child development; psychopathology; family systems; and multi-cultural diversity and care; or

- B. Supervised Professional Experience: At least one year of supervised experience under a licensed practitioner or a BCBA who is also a licensed practitioner who meets all of the following (i) works within such individual's scope of practice, (ii) have experience in providing applicable ASD services and (iii) already meet the requirements of this subsection. Supervised professional experience may overlap with one or more years of professional experience described in (2) above.

Technician's Qualifications

ASD treatment services may be provided by an unlicensed professional under the direct supervision of a Medicaid enrolled licensed practitioner/provider or BCBA who is qualified to provide ASD services. Effective immediately, the technician must meet at least the following minimum qualifications as set forth in section 17a-262-1058(f) of the regulation:

1. Education and Experience: Have either (A) A bachelor's degree from an accredited college or university in a behavioral health field, behavior analysis, or a related field, plus one year of full-time equivalent experience working with children with a diagnosis of ASD, or (B) An associate's degree or an equivalent number of credit hours with a passing grade from an accredited college or university in a behavioral health field, behavior analysis, or a related field, plus two years of full-time equivalent experience working with children with ASD; and
2. 18 hours of continuing education in ASD services within the last three years.

For questions about ASD provider qualification requirements, please contact the Department of Developmental Services, Division of Autism Spectrum Services at (860) 418-6078.

PROCEDURE CODES

The following procedure codes will be used for all providers:

Comprehensive Diagnostic Evaluation:

The Comprehensive Diagnostic Evaluation (CDE) determines the individual's diagnosis and makes general ASD treatment recommendations. It can be completed in one day or over multiple days. If the practitioner diagnoses the individual with ASD based on the comprehensive diagnostic evaluation, the practitioner should refer the individual for a behavior

assessment to identify more specific interventions which would be useful in treatment.

There is no HIPAA compliant procedure code specifically for a comprehensive diagnostic evaluation of ASD. The most appropriate code found is:

0359T- *Behavior identification assessment, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report.*

This is not a time-based code. The Department will use this code with various modifiers, as described below, to reimburse for the CDE. It is understood that based on the clinical presentation and individual treatment history this evaluation could vary considerably in duration and be completed in one day or over multiple days. For a routine evaluation lasting 3-5 hours on a given day the provider should bill using code 0359T without any modifier. This will result in payment at the base rate for that provider based on their licensure/certification. For expanded services, defined as greater than 5 hours on a single day, the provider should bill for 0359T with the modifier 22 (expanded scope). This will increase reimbursement for that day by 50% from the base rate. For reduced services, defined as greater than one hour but less than 3 hours the provider should bill for 0359T using the modifier 52 (reduced scope). This will reduce reimbursement for that day by 50% from the base rate.

For any service provided that is less than one hour, the provider should contact the Administrative Services Organization (ASO) to seek authorization for the service that was provided (e.g. psychiatric diagnostic evaluation, brief emotional/behavioral assessment with scoring and documentation, per standardized instrument, etc.).

If the provider needs more than one day to complete the evaluation, the same code and modifiers can be used for each date of the evaluation. For example, if a provider does a 6 hour evaluation on a single date, they will bill for 0359T – 22 for that date. If the evaluation is done over a period of four hours on the first day and two hours on the second, the provider would bill for 0359T for the first date and 0359T – 52 for the second date.

Behavior Assessment

H0031: *mental health assessment by a non-physician.*

For the purposes of ASD services, one hour of behavior assessment equals one unit of service.

Plan of Care

H0032: *mental health service plan by a non-physician.*

For the purpose of ASD services, development of the written plan of care equals one unit of service.

Treatment Intervention Services

H2014: *skills training and development, per 15 minutes*

AUTHORIZATION OF SERVICES

All services listed above require prior authorization (PA) from the Medicaid Behavioral Health Administrative Services Organization (ASO). For information on requesting PA, please refer to Chapter 9, available on the www.ctdssmap.com Web site, by selecting “Information” and “Publications”. Questions about the authorization process can be directed to the ASO at 1-877-552-8247.

ASD treatment intervention services may be authorized only if the comprehensive diagnostic evaluation diagnoses the member with ASD and the behavior assessment and Plan of Care specifically support the request for authorization as medically necessary.

Comprehensive Diagnostic Evaluation: One unit may be authorized per day. Additional units requested will be based on medical necessity. Requests for PA for code 0359T do not need to include the modifier since the provider might not know in advance the duration of services for any given day. The modifier, if appropriate, must be included on the claim form and justified in the medical record.

Behavior Assessment: Behavior assessment authorizations will be based on the individual needs of the member. Requests for authorizations should be submitted with the number of hours/units the provider deems necessary to complete the assessment.

Plan of Care: One unit may be authorized to support the development of the Plan of Care and medically necessary updates to that Plan of Care.

Treatment Intervention Services: All requests for treatment intervention services must include a comprehensive diagnostic evaluation performed within the previous twelve months of the authorization request for treatment services. Additional information and documentation required includes:

- Requested interventions, types, frequency, intensity, setting, and duration of the services with an explanation and supporting documentation showing how the specific requested services are medically necessary;

- the plan of care to support the request for authorization (completed or updated within 120 days of the request for treatment services);
- the behavior assessment (described above, completed or updated within six months of the request for treatment services);
- severity scores, skills-based assessment scores, adaptive scores;
- the most recent medical/physical evaluation (described above, completed or updated within the last twelve months of the request for treatment services);
- the comprehensive diagnostic evaluation (described above, completed or updated within twelve months of the request for treatment services); and
- as applicable, school evaluation and Individualized Education Program (IEP), Individual Family Service Plan (IFSP) for members under the age of three (3), and any other available evaluations or relevant documents.

Initial authorization will last for up to forty-five (45) days in order to determine the quality of the baseline data. The first continued stay authorization may be authorized for up to six (6) months. Subsequent continued stay reviews must include an updated plan of care that specifically includes progress toward goals on the initial plan of care. After one (1) year of service, every continued stay review must include a comprehensive review of goals met, summary of data indicating progress toward goals, anticipated benefit of the intervention for the member, updated Plan of Care, and the most recent IEP or IFSP, if applicable.

Supervision:

All treatment intervention services must be supervised by one of the qualified licensed professionals identified above working within his/her scope of practice or a BCBA working within his/her scope of practice. Supervision of staff providing the intervention services must be done one-to-one and documented in the medical record on a weekly basis for all members in care. One (1) hour of direct supervision is required for every ten (10) hours of treatment services. Supervision must include direct observation of the staff person with the member.

Special Policy Considerations Based on Provider Types:

Currently enrolled licensed CMAP providers may provide ASD diagnostic, assessment and treatment services using their existing Medicaid provider identification number as long as they are operating within the scope of their license and have the expertise

and experience in providing autism services that are described in the Provider Qualifications section of this policy transmittal. No change to the provider's enrollment is required at this time.

The Department [has] opened up enrollment for BCBA's to join the CMAP network effective January 1, 2015. Specific instructions on the enrollment process for BCBA's will be in a separate transmittal.

Hospital Outpatient: Since there are no sufficient appropriate revenue center codes for hospital claims for each of the ASD diagnostic and treatment services, physicians within a hospital outpatient program will be required to use their physician group practice provider type/specialty in order to submit claims.

REIMBURSEMENT RATES

The applicable ASD evaluation and treatment intervention reimbursement rates are attached. There are different schedules for:

- Physicians, APRNs, and Physician assistants. Note that consistent with current policy, the APRN and PA services are paid at 90% of the published physician fee schedule amount.
- Psychologists
- Behavioral Health Clinicians
- Behavioral Health Clinics
- Board Certified Behavior Analysts

Additional ASD Services Available to Members and Families:

In addition to the Medicaid evaluation and treatment services described above, the behavioral health ASO will provide additional support services to members with ASD, including adults and family members. Support services include care coordination, family navigators, and peer specialists. These support services are designed to support the needs of members and/or their families in need of ASD services. The ASD Care Coordination Unit at ValueOptions can be reached by calling 1-877-552-8247.

DOCUMENTATION

All services must be documented accurately in the medical record. The documentation in the medical record must include the intervention provided, the name and credentials and signature of staff performing the service, the actual time of the service, the location where the service was provided and the date. The behavioral health ASO will be responsible for conducting chart reviews of providers at the outset of implementation. Chart reviews will include comprehensive diagnostic evaluations, behavior assessments, plans of care, and treatment progress notes.

Billing Questions

For billing questions, please contact the HP Provider Assistance Center, Monday through Friday from 8:00 a.m. to 5:00 p.m. at 1-800-842-8440.

Posting Instructions: Policy transmittals can be downloaded from the Web site at www.ctdssmap.com.

Distribution: This policy transmittal is being distributed by HP Enterprise Services to providers enrolled in the Connecticut Medical Assistance Program.

Responsible Unit: DSS, Division of Health Services, Integrated Care Unit, William Halsey at (860) 424-5077.

Date Re-Issued: October 2015

Autism Spectrum Disorder (ASD) Reimbursement Rates Effective 1/1/15

Billing			Provider Type					
Code	Description	Units	MD	APRN/PA	Psychologist	Clinic	LCSW/LMFT/LPC	BCBA
0359T	Diagnositc Eval (3-5 hrs)	One Per day of one of these	\$ 720.00	\$ 648.00	\$ 612.00	\$ 612.00	\$504 (LCSW only)	n/a
0359T-22	Expanded Eval (5 or more hrs)		\$ 1,080.00	\$ 972.00	\$ 918.00	\$ 918.00	\$756.00 (LCSW only)	n/a
0359T-52	Reduced Eval (1-3 hrs)		\$ 360.00	\$ 324.00	\$ 306.00	\$ 306.00	\$252.00 (LCSW only)	n/a
H0031	Behavior Assessment	Per Hour	\$ 112.00	\$100.80	\$ 95.20	\$ 78.40	\$ 78.40	\$ 78.40
H0032	Treatment Plan development	Per Plan	\$ 112.00	\$ 100.80	\$ 95.20	\$ 78.40	\$ 78.40	\$ 78.40
H2014	Treatment Services	Per 15 minutes	\$ 14.12	\$ 12.70	\$ 12.00	\$ 12.00	\$ 9.88	\$ 12.00