Acentra HEALTH

Autism Spectrum Disorder

Provider Education 2024

Partners in Healthcare – Who are we?

- Acentra Health (formerly Kepro and CNSI) 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 are a team of experienced leaders, caring clinicians, pioneering technologists, and industry professionals who come together to redefine expectations for the industry.
- We provide:
  - Medical necessity reviews for multiple services
  - Level of Care reviews
  - Post-Payment reviews

CMS-Certified Solutions

CMMI Level 4 Appraisal

URAC Accredited

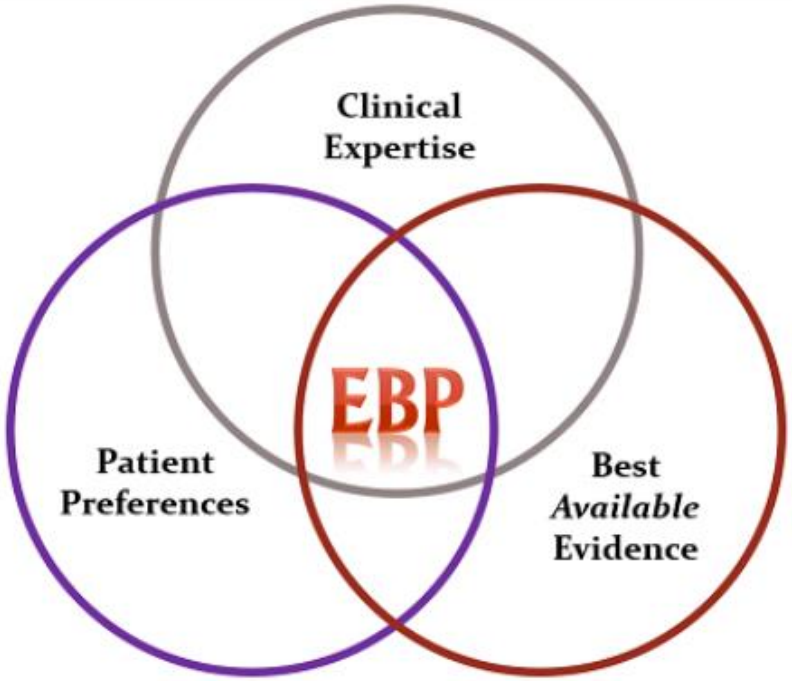
HITRUST Certified

Autism Spectrum Disorder

- Services to treat Autism Spectrum Disorder (ASD), as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), are provided to eligible Medicaid beneficiaries ages 0 to 21. 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

- SCDHHS requires the use of evidence-based practices to ensure thorough and appropriate screening, evaluation, diagnosis and treatment planning,
- Evidence-based Practices (EBP) are defined as mental and behavioral health interventions for which systematic empirical research as provided evidence of statistically significant effectiveness as treatments for specific problems.
- ASD services must be determined medically necessary to be eligible for Medicaid Reimbursement
- Services must pe authorized by Acentra Health PRIOR to service delivery.



Autism Spectrum Disorder

Basic Requirements for services

- Primary diagnosis of Autism Spectrum Disorder
- Age 0-21 and medically necessary
- Recommended by a licensed psychologist, developmental pediatrician, or Licensed Psycho-educational specialist within his or her scope of practice
- Comprehensive psychological testing performed

**detailed program features can be found in the SCDHHS Autism Spectrum Disorder Provider Manual

Prior Authorization Requests

Codes Requiring Authorization

Currently requires authorization	
97153	97154
97155	97156
97158	

EFFECTIVE 7/1/2024

97152	Behavior Identification Supporting Assessment
97157	Multi-Family Group Adaptive
0362T	Behavior Identification Supporting Assessment – 2 or more technicians
0373T	Adaptive Behavior Treatment, 2 or more technicians

Prior Authorization Requests

Authorization requests should always be submitted prior to services being rendered

Authorization requests may be submitted online at https://portal.kepro.com or by fax using the SCDHHS ABA Prior Authorization Request form.

For assistance with the Atrezzo portal please call 1-855-326-5219

Beneficiaries with other health insurance do not require a PA from Acentra Health UNLESS requested service is a non-covered service or benefits have been exhausted by primary insurance.

An explanation of benefits or statement of non-covered benefit is required before a PA can be issued.

Authorization Types

❑ Prior Authorization

Should always be submitted on or before the service begins:

Initial
Continued
Annual

❑ 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.
- Providers must identify a request as RETRO on the fax request form or by request type in Atrezzo.

Initial Treatment requests

***Initial* Treatment Request must include:**

- Comprehensive psychological assessment/testing report
- Behavior Identification Assessment
- Individual Plan of Care (IPOC)

IPOC must include:

- Member's strengths, needs, abilities, & preferences
- Assessment & evaluation results
- 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
- Amount/ type of parent/caregiver participation if applicable
- Signature, title and date of multidisciplinary team members
- Signature and date of the parent/caregiver

Continued treatment requests

***Continued* Treatment Request must include:**

- Most recent IPOC with a recent dated signature
- Progress Summary

Progress Summary must include:

- Specific objective(s) from the IPOC toward which treatment is focused
- Outline of specific treatment activities or interventions
- Goals – progress toward goals; explanation of any delayed progress toward IPOC goals
- Cumulative graphs of goals and objectives demonstrating progress or areas of concern
- 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
- Signature and date of parent/caregiver

Annual treatment requests

***Annual* Treatment Request must include:**

- **New** Behavior Identification Assessment results
- Updated IPOC
- Updated progress summary

IPOC & Progress Summary must include:

- Information from page 9-10
- Updates must span the previously authorized treatment periods

*It is important to show progress of each goal identified in IPOC – paint a picture of the child's progress, or delay in progress

Documenting Medical Necessity

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

- Member's name and date of birth
- Date of the evaluation session and date of the report
- Referral question and/or reason for assessment
- Administered tests
- Medical history and medications
- Family history
- Psychological and/or psychiatric treatment history, including previous testing and assessment reports
- Substance abuse history
- Member and/or family strengths and support system
- Exposure to physical abuse, sexual abuse, anti-social behavior and other traumatic events
- ASD diagnosis AND severity level
  - Assessments conducted prior to member's fourth birthday must reflect a presumptive diagnosis
- Recommendations for additional services, support or treatment
- Name of the psychologist, Licensed Psycho-educational specialist, or Developmental Pediatrician, title, signature and date

Documenting Medical Necessity – New diagnosis

IN ADDITION

Psychological Assessment Report for NEW beneficiaries must include:

- Clinical interview with member and/or family members as appropriate
- Review of the presenting problems, symptom, deficits, strengths, history and any past psychological reporting
- Behavioral observations in one or more settings
- Autism Diagnostic Observation Schedule (ADOS)
- Standardized measure of intelligence (WISC, WAIS, Stanford-Binet, Bayley Scales, etc.)

Assessment may also include:

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

*list is not exhaustive, but the measures utilized must be standardized

Documenting Medical Necessity – previous diagnosis

IN ADDITION

Psychological Assessment Report for previously diagnosed beneficiaries must include:

- Clinical interview with member and/or family members as appropriate
- Behavioral observations in one or more settings
- At least 3 of the following:

ADOS	GARS
ABBLS-R	VINELAND
ADI	SRS
BASC	SCQ
CARS	

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

Standardized measure of intelligence (WISC, WAIS, Stanford-Binet, Bayley Scales, etc.)

*list is not exhaustive, but the measures utilized must be standardized

Documenting Medical Necessity

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

- Administration of standardized and non-standardized tests
- Detailed behavior history
- Patient observation & caregiver interview
- Interpretation of test results
- Discussion of findings
- Recommendations with the primary guardian(s)/caregiver(s)
- Vineland
- At least 2 of the following:
  - Pervasive Developmental Disorder Behavioral Inventory
  - Social Responsiveness Scale
  - Verbal Behavior Milestones Assessment & Placement Program
  - Assessment of Functional Living Skills
  - Essentials for Living
  - Assessment for Basic Language & Learning Skills
  - Promoting the Emergence of Advanced Knowledge – Comprehensive Assessment

Processing Timelines

Acentra Health completes requests for services expeditiously and within contractual timeframes. The review completion timeframe is measured from the date Acentra Health receives a request.

- New Request/Admission review – 5 business days
- Retrospective Reviews – 5 business days

Review Process

Administrative Requirements

- Member eligibility verified
- Provider eligibility verified
- Medicaid Guidelines applied

Nurse Review

- InterQual® or State defined criteria applied
- May pend for additional clinical information
- Approve if criteria met
- Refer to physician reviewer if documentation does not support medical necessity.

Physician Review or BCBA-D

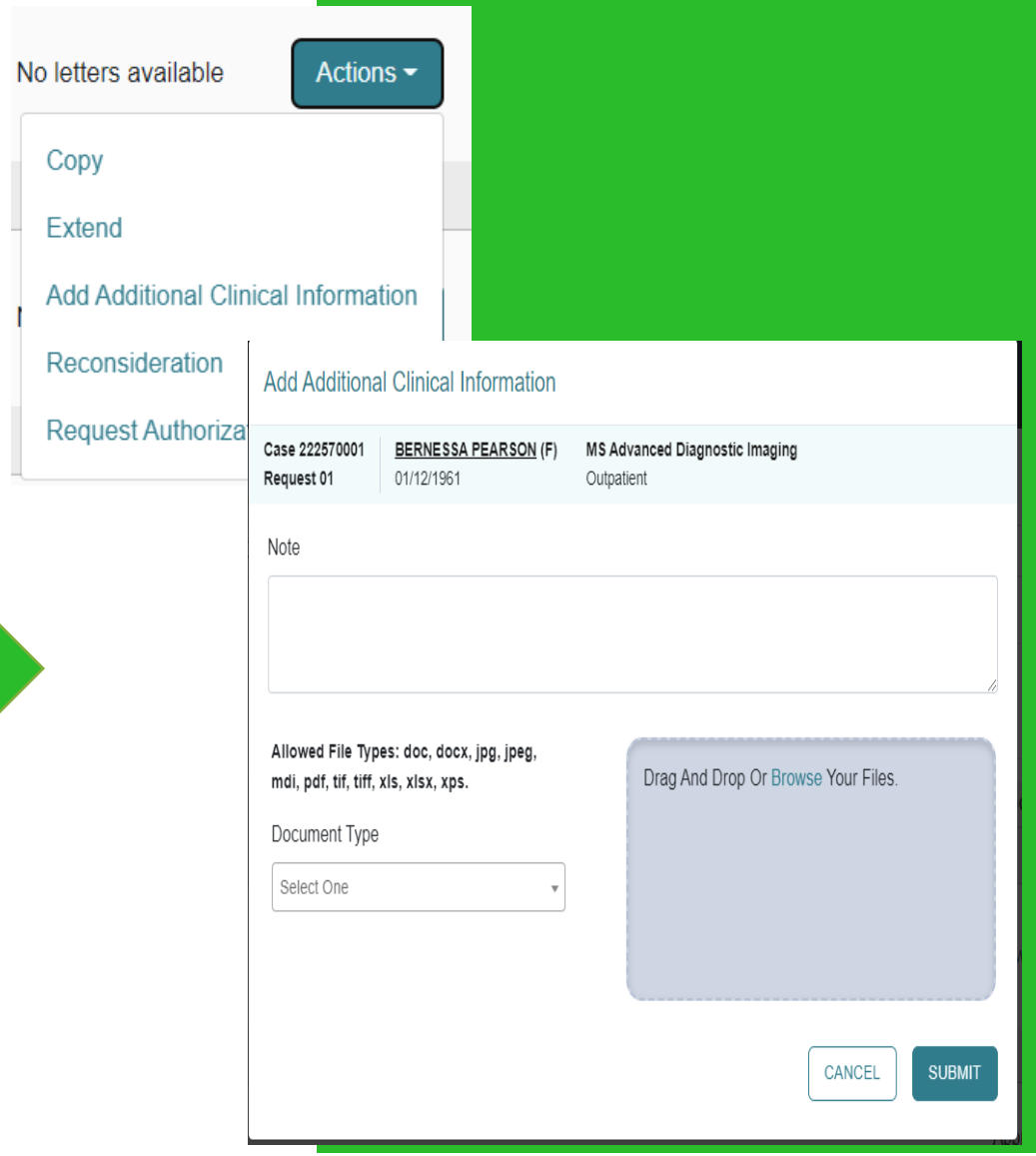
- The medical director, or another qualified physician reviewer (BCBA-D for ASD) will review the case against InterQual® or State defined criteria and national standards to provide a decision
- The physician or qualified practitioner may approve or deny the review

Pended Reviews

- A review may be pended for one of the following reasons:
  - Missing required information such as plan of care or provider number
  - Additional information or clarification is needed before a decision can be made
- Notifications are sent via fax and web portal
- A provider has 2 business days to respond to the additional information request
  - If the case contains no clinical information, the case will be administratively denied
  - If the case has insufficient clinical information and there is no response to the pend, the case will move to the physician reviewer (BCBA-D) for a determination
- If a review is administratively denied, the provider may submit a new request once they have all the necessary information

Responding to Pended Reviews

- If you submitted the request online thru the Portal:
  - Log into the Portal and open the pended case
  - ACTION TAB – additional Clinical Information
  - Upload the requested documents or type the information in the note section



Denials and Reconsiderations

Administrative Denial

- When any portion of the review is denied because it does not comply with Medicaid regulations
- Example: untimely, required documentation not received
- Provider may submit a new case for the service if an administrative denial is received.

Clinical Denial

- Occurs when any portion of the requested service is denied by a physician reviewer (BCBA-D) due to not meeting medical necessity
- Does not meet state Medicaid criteria with information submitted or does not meet other national evidence-based criteria

Reconsideration

- May only be requested for clinically denied cases
- Not used for Administrative Denials

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
  - phone *least preferred (will still require additional information to be faxed)
- A clinical reviewer will review any additional information submitted. If unable to meet State approved criteria, it will be referred to the physician reviewer (BCBA-D)
- A physician reviewer – a different physician from the one who originally reviewed the case - will look at the case and any new information submitted to support the reconsideration
- The physician 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

- If a reconsideration is upheld, an appeal may be requested. Specific instructions will be included in the reconsideration determination letter.
- SCDHHS will review the provider's request and conduct an internal review or Fair hearing.
- Members 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@kepro.com generic questions please, do not include PHI