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Follow up from the June 2024 Autism Spectrum Provider Education Webinars

Q&A

"**What are the max units per day or auth for 0373T?"**

Max units per day for 0373T will be 21 units per day.

"Will there be any consideration to increase the limit on 97155? Currently, we cannot request more than 16 hours/month through the portal."

According to the SCDHHS Autism Spectrum Provider Manual, January 1, 2024 version, Section 4: 97155 has a frequency limit of 64 units per month, to be rendered at a rate of 10% weekly therapy hours. (1 unit = 15 minutes, 4 units per hour x 16 hours= 64 units)

The Acentra Health web portal is designed to follow the frequency limit guidelines.

Annual assessment authorization - Does a child who has an ASD diagnosis on file still have to have new testing every year? Please clarify.

According to the Autism Spectrum Disorder Provider Manual, January 1, 2024 version, "For annual treatment reviews, new Behavior Identification Assessment results, updated IPOC and progress summary spanning the previous authorized treatment period must be submitted to the QIO with the SCDHHS ABA Prior Authorization Request Form. Annual treatment requests can be submitted up to 30 days prior and no later than 10 days prior to the expiration of authorized visits. Failure to obtain reauthorization prior to the provision of services may result in a denial of claims."

"What is timely filing limit for Medicaid secondary claims? When filing claims that we have authorization from primary insurance?"

Please visit the SCDHHS Provider Administrative and Billing Manual for all rules related to filing claims to SC Medicaid. "Medicaid will pay claims that are one year from the date of service. If the date of service is greater than one year, Medicaid will not make a payment. The one-year time limit does not apply to retroactive eligibility for beneficiaries" page 55.

“How do you bill 97152? Once a year for RBT to gather statistics when BCBA is billing for annual assessment under 97151? What is the daily unit limit for 97152?”

Please visit the SCDHHS Provider Administrative and Billing Manual for all rules related to billing or contact the SCDHHS Provider Service Center at 1-888-289-0709. Acentra Health is unable to provide guidance or advice on billing rules for SC.

The daily unit limit for 97152 is 21 units per day.

Can we get a copy of these slides?

The PowerPoint presentation will be uploaded the SCDHHS.Acentra.Com under Resources and Training>PowerPoint Presentations and Training Materials>Autism Spectrum Disorder (ASD).

Is there a recommended format for submitting a progress report for ABA services?

Acentra Health suggests using the information found in the Autism Spectrum Disorder Provider Manual outlining Progress Summary Reports. The progress summary must include:

• The specific objective(s) from the IPOC that were a focus of treatment.

• Specific treatment activities or interventions.

• The goals that have been met.

• Cumulative graphs of goals and objectives demonstrating progress or areas of concern (ABA providers only).

• Explanation of any delayed progress, to include any barriers to progress, toward IPOC goals.

• Explanation of any failure to provide the recommended services and their frequency

. • Amount and type of parent/caregiver participation, as applicable to the beneficiary. • Summary of the treatment plan for the upcoming treatment period, to tie into objectives and goals of the IPOC.

• Signature, title and date by the multidisciplinary team members including the parent and/or caregiver.

Is a Prior Authorization still needed for 97151?

Prior authorization is not required for 97151.

Is there a way to get more in-depth information about procedure codes and what you can do for each procedure code, specifically 97155.

Please refer to the SCDHHS Autism Spectrum Disorder provider manual, January 1, 2024 version, Section 4. Any additional questions may be addressed to the SCDHHS Provider Service Center at (888) 289-0709.

If no authorization is needed for people that have other insurance, how do we bill for coinsurance/deductible etc. when you need a PA number to bill.

Prior authorization is not required from Acentra Health when a member has other primary health insurance UNLESS the primary insurance **denies** your claim for exhausted benefits or noncovered services.

Rules of the primary insurance must be followed (including prior authorization and documentation requirements). Once a claim is filed to the primary insurance and adjudicated/processed/completed, the provider will then submit a claim to SC Medicaid following the rules outlined in the Provider Administrative and Billing Manual – you must include a copy of the member's primary EOB or remittance.

If the **primary** insurance denies the member's claims for exhausted benefits or noncovered services, the provider may submit a prior authorization request for the service dates denied. Medical necessity documentation and a copy of the EOB or remittance are required. Acentra Health will process the review and make a determination within 5-6 days. A secondary claim can then be filed to SC Medicaid.

If you do not need a PA number for 97151 but you need an auth for the new 97152 how does that work?

97152 requires prior authorization, therefore providers must request authorization for this service through Acentra Health for Fee for Service members. Providers may submit online using the ANG portal or via fax using the Acentra Health Prior authorization form.

If we just got a new auth, do we submit another auth to request the addition of 97152? How do you /accentra base necessity of 97152?

After July 1, providers who may need to perform 97152 may submit a request to add 97152 to an existing, active authorization. The Start Date will be the day you submit the

request or later date chosen by the provider; however, Acentra Health will process the end date to match your existing authorization.

When requesting 97152, if adding to an existing authorization will it affect already awarded number of units of the other codes (97153 and/or 97155)

If a provider requests 97152 to be added to an existing authorization, Acentra Health will not modify any previously approved units on the authorization. It is the responsibility of the provider to calculate the units required to provide the recommended services outlined in the member's treatment plan and request that number of units with each CPT code and authorization, ensuring the requested units are supported by medical necessity documentation and are not excessive.

Do we know if this will be the same with MCO's in terms of being able to request 97152 after July 1?

According to the Provider Bulletin from June 12th, Medicaid managed care organizations (MCOs) are responsible for the authorizations, coverage, and reimbursement related to the services described in the bulletin/announcement. Any questions regarding the MCO's can be directed to the Provider Service Center at (888) 289-0709.

How do we sign up for bulletins?

Healthy Connection Medicaid bulletins can be found at https://www.scdhhs.gov/communications

There will be an opportunity to subscribe to bulletins and updates on the right side of the page.