PART II

POLICIES AND PROCEDURES
for
AUTISM SPECTRUM DISORDER (ASD) SERVICES

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION of MEDICAL ASSISTANCE PLANS

Version Date: July 1, 2026

TABLE OF CONTENTS

Policy Revision Record
[from 2024 to Current[1]

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE	CITATION
			A=Added **D**=Deleted **M**=Modified	(Revision required by Regulation, Legislation, etc.)
07/2024	Section 601.1.2	Added guidance related to provider location	A	
07/2024	Section 602.2	Added guidance related to provider location when rendering services	A	
07/2024	Section 601.3	Clarified the difference between "supervision" and "direction"	A	
07/2024	Appendix A – Location Code	Added verbiage: provider must be in Georgia or within 50 miles of the border for "Telemed"	A	
07/2024	Appendix F	Added "***Electronic Signatures: Refer to section 602.3"*** under BCBA signature	A	
07/2024	Appendix G	Increased provider's PA submission ability from 60 days to 90 days of the effective treatment date	M	
07/2024	Appendix F	Added verbiage prohibiting the concurrent billing of 97154/97158	A	
07/2024	Appendix G	Added Section H - PA Submission User Manuals	A	
07/2024	602.2 and Appendix A-Location Code	Removed reference to provider location as it relates to telehealth	D	
07/2024	Appendix A	Added verbiage referring providers to the Telemedicine Guidance policy manual	A	
10/2024	Appendices B, C, and D	Consolidated to Appendix B	M	
10/2024	Appendices E, F, and G	Renamed to C, D, and E respectively	M	
10/2024	Appendix D	Added "If yes, please provide the school schedule" after the question "Is this member currently enrolled in school"?	A	
10/2024	Section 701.1.1	Added General Eligibility requirement as a reminder: *The member's Medicaid benefits must be active on the date of service. As outlined in Section 107.1 of the Part I Policies and Procedures for Medicaid/Peachcare for Kids manual, "It is the responsibility of the provider to verify Medicaid/PeachCare for Kids eligibility on each date of service".*	A	
10/2024	601.1.2	Revised to "physically reside and practice" as it relates to the location requirements for providers to enroll	M	
10/2024	Appendix E(B)(vii)	Added a third option for preventing overlapping PAs; withdrawing. Revised verbiage in #2, End-dating PAs	M	
10/2024	Appendix	Updated verbiage related to submitting PA 90 days in	M	

	E(B)(vi)	advance.		
1/1/2025	804.11	Added guidelines related to behavior reduction line graphs in the school setting	A	
1/1/2025	804.12	Added IEP/IFSP/504 plan requirement for school-based services	A	
1/1/2025	Appendix D	Added IEP/IFSP/504 plan requirement for school-based services	A	
1/1/2025	Appendix D	Revised educational placement question and added reference to 504 plan	R	
1/1/2025	Appendix D	Included reference to homeschool	A	
4/1/2025	Appendix D	Removed Skill acquisition exclusion from school plan guidance	M	
4/1/2025	Appendix D	Added “for members enrolled in a public school” in section requestion IEP/IFSP/504 plan	M	
4/1/2025	601.1.1	Removed Advance Nurse Practitioner from providers authorized to provide ASD services. This was erroneously added during the manual reformat.	D	
7/1/2025	602.3.4	Added “Secure” to electronic signatures and updated the Part I manual policy location	M	
7/1/2025	Appendix D	Updated location of electronic signature guidance from 602.3 to 602.3.4	M	
7/1/2025	701.1.1	Revised verbiage related to retroactive PAs.	M	
7/1/2025	Appendix E	Combined sections C and H	M	
7/1/2025	701.1.1	Added language related to retroactive eligibility and retro PAs	A	
7/1/2025	804.10	Added reference to caregiver training in the school setting	A	
7/1/2025	Second Paragraph Following 804.12	Added language related to caregiver training for school personnel	A	
7/1/2025	804.11	Added language related to insufficient progress	A	
7/1/2025	803.5	Added additional guidance for updated data	A	
7/1/2025	Appendix D	Removed school personnel training exclusion	D	
7/1/2025	Appendix D	Moved service schedule to first page	M	
10/1/2025	802	Added Essentials for Living	A	
10/1/2025	601.1.2	Revised Enrollment to include new Group Enrollment guidelines.	M	
10/8/2025	Appendix A	Updated rates to reflect increase	M	
10/8/2025	Appendix C	Removed rate tables	D	
1/1/20206	Appendix F	Added new appendix for the Treatment Plan Template	A	
1/1/2026	804	Added language to communicate the addition of the Treatment Plan Template in Appendix F	A	
1/1/2026	803.9	Modified this section to reference progress summaries	M	
1/1/2026	Appendix D	Added “summary” to #4 and added “treatment strategies to include antecedent and consequence, replacement behaviors” to #6	A	
1/1/2026	Appendix E,	Added “If a denial is documented in the portal, you can view	A	

	Section C	the reasoning by hovering over the denial status to display the details" to Reconsideration Requests		
1/1/2026	Appendix E, Section B(vii)	Added guidance to end dating/withdrawing PAs	A	
1/1/2026	Appendix E, Section E	Added guidance related to change requests	A	
1/1/2026	803	Revised guidance related to the behavioral assessment and the POC	M	
1/1/2026	Appendix D	Revised the order of the coversheet	M	
1/1/2026	Appendix E, Section B (vi)	Revised policy allowing PAs to be submitted 90 days in advance	M	
4/1/2026	Appendix E, Section B (vii)	Added "change request" as the only method to end date/withdraw PAs. Also, added the option to use discharge summary to end PA.	M	
4/1/2026	Appendix E, Section B (viii)	Updated the PA TAT from 45 days to 7 days	M	
4/1/2026	Appendix E, Section B (ix, x, xi)	Revised existing content into subsections covering backdating PAs, Katie Beckett retro, and terminated/later-reinstated members.	M	
4/1/2026	Appendix E, Section B (xii)	Added guidance to transfer a MCO PA to FFS	A	
4/1/2026	Appendix F	Revised the description of the template to communicate that the template is not required but the guidance is.	M	
4/1/2026	601.2	Revised verbiage to outline billing for uncredentialed/unenrolled providers	M	
4/1/2026	Appendix E, Section D(i)	Added verbiage advising providers to utilize "contact us" to discuss denials	A	
4/1/2026	Appendix E, Section F (iv)	Added "To end date or withdraw a PA" as an option	A	
4/1/2026	Appendix E, Section D (v)	Removed this section	M	
4/1/2026	Appendix E, Section A	Added the phases of the review process	A	
4/1/2026	Appendix E, Section D (i)	Added to #3 that the 10 days do not apply to overlapping PA denials.	A	
4/1/2026	Appendix E, Section G	Removed GAMMIS image	M	
4/1/2026	Appendix D, Section A	Added verbiage advising that GARS/CARS cannot be accepted for both clinician and caregiver tools	A	
4/1/2026	Appendix D	Added "Modified Schedule" to line requesting school schedule.	A	
4/1/2026	Appendix E, Section B (vii)	Updated overlapping PA guidance due to consolidated PAs	A	
4/1/2026	Appendix E, Section B (xiii)	Added guidance related to Consolidated Prior Authorization Requirements for Ongoing Assessment and Treatment Services	A	

4/1/2026	Appendix D	Added that school plans for daycares and after-school programs provided as a provision of IDEA are required.	A	
4/1/2026	Appendix D	Added date range sections for consolidated PA dates	A	
7/1/2026	601.1.2	Revised provider enrollment requirements	M	
7/1/2026	Appendix E, Section B (xi-xii)	Revised these sections related to retroactive PAs	M	
7/1/2026	Below 803.11	Added new guidance related to treatment requests over 30 hours/week	A	
7/1/2026	Appendix D	Revised the reference section for consolidated PAs listed on the date range section of the cover sheet.	M	
7/1/2026	Appendix F	Guidance for group goals revised	M	
7/1/2026	Appendix E, Section B (vi)	Updated guidance related to how far in advance PAs may be submitted	M	
7/1/2026	601.1.2	Added verbiage advising that the provider listed on the claim must be the one who rendered the service.	A	

[1] The revisions outlined in this Table are from July 2024 to current. For revisions prior to 2024, please see prior versions of the policy.

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:

601.1.1.1. Licensed Physician (with or without BCBA certification):

601.1.1.1.1. May be the enrolled QHCP.

601.1.1.1.2. May supervise the work of BCaBAs and RBTs who implement behavior-analytic interventions.

601.1.1.2. Licensed Psychologist (with or without BCBA certification):

601.1.1.2.1. May be the enrolled QHCP.

601.1.1.2.2. May supervise the work of BCaBAs and RBTs who implement behavior-analytic interventions.

601.1.1.3. Board Certified Behavior Analyst- Doctoral Level (BCBA-D):

601.1.1.3.1. A doctoral level independent practitioner qualified to provide behavior-analytic services/ direct services.

601.1.1.3.2. May be the enrolled QHCP.

601.1.1.3.3. May supervise BCaBAs, RBTs and others who implement behavior-analytic interventions

601.1.1.4. Board Certified Behavior Analyst (BCBA)

601.1.1.4.1. A masters/graduate level independent practitioner qualified to provide behavior-analytic services/direct services.

601.1.1.4.2. May be the enrolled QHCP.

601.1.1.4.3. May supervise the work of BCaBAs and RBTs who implement behavior-analytic interventions.

601.1.1.5. Board Certified Assistant Behavior Analyst (BCaBA):

601.1.1.5.1. Bachelor's level practitioner - May not be the enrolled QHCP.

601.1.1.5.2. Must be supervised by a physician, psychologist, or BCBA/BCBA-D

601.1.1.5.3. May supervise the work of RBTs.

601.1.1.6. Registered Behavior Technician (RBT):

601.1.1.6.1. Paraprofessional who implements the service plan under supervision of a BCBA/BCBA-D

601.1.1.6.2. May not be the enrolled QHCP.

601.1.1.6.3. Must be supervised by a BCBA/BCBA-D or BCaBA

601.1.2. Enrollment

Providers who submit professional claims and have two or more individuals in their practice must enroll as a group. This applies to practices with multiple clinicians, such as therapy centers, behavioral health groups, or medical offices.

Individual practitioners—including physicians, psychologists, BCBAs-D, and BCBAs—must enroll as rendering providers linked to the group or facility through which they deliver services.

To enroll as a Medicaid provider, the practitioner must reside in Georgia or within 50 miles of the Georgia border and must hold an active license issued by the Georgia BCBA Licensure Board.

More information about Group Enrollment can be found in the "Group Billing Enrollment FAQs" available at https://www.mmis.georgia.gov/portal/Default.aspx?tabid=24.

Providers must bill using the appropriate practitioner type and service code for the service delivered. For RBT or BCaBA rendered services, such as 97153, the supervising BCBA must be identified as the rendering provider on the claim in accordance with Medicaid billing requirements. The RBT or BCaBA delivering the service is responsible for completing and signing the daily session or progress note, with clinical oversight provided by the supervising BCBA in accordance with BACB

requirements.

Note: BCaBAs and RBTs are not enrolled directly by the Division as providers because they are not considered independent practitioners. Level 4 and 5 practitioners work under the supervision of higher-level practitioners.

601.2. Standard Billing Practices

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.

Providers agree to bill the Division only for services they personally render or for services delivered by a Qualified Health Care Professional under their direct supervision, consistent with O.C.G.A. Title 43, Chapter 11. Billing is not permitted for services rendered by another practitioner who is enrolled, or eligible to enroll, as a Medicaid provider. Services delivered by individuals who are not fully credentialed or not enrolled in the Medical Assistance program are not billable. The Department does not provide a grace period for certification or enrollment; all practitioners must hold the required certification at the practitioner level for which services will be billed and be fully enrolled with Georgia Medicaid, as applicable.

601.3. Direct Supervision

601.3.1. Supervision

"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.

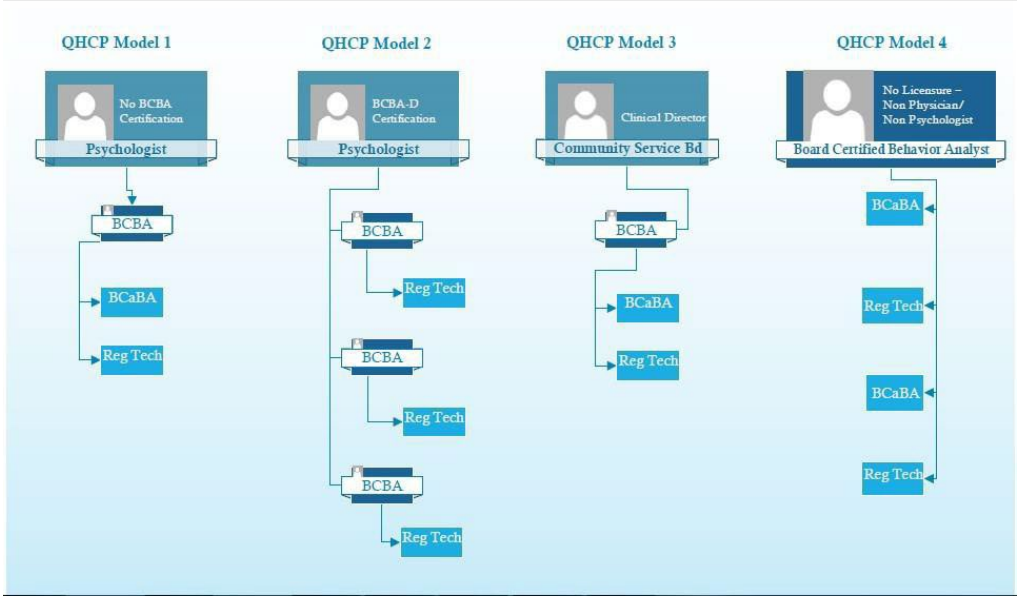
The Qualified Health Care Provider (QHCP) must supervise non-enrolled practitioners who are involved in the delivery of Adaptive Behavioral Services (ABS) to Medicaid members with ASD and for which such services are being claimed to Medicaid under the enrolled provider identification number of the QHCP 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. **Please note that "supervision" is <u>not</u> separately reimbursable as it is built into the direct service codes rates; however, "direction" may be separately reimbursable.**

601.3.2. Direction

Direction of a technician includes, but is not limited to, the QHP observing the technician implementing the patient's protocols with the patient and providing instructions and corrective feedback as needed and/or demonstrating correct

implementation of a new or modified treatment protocol with the patient while the technician observes followed by the technician implementing the protocol with the patient while the QHP observes and provides feedback. This service should be reported and billed using code 97155 (adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional). The technician's time is separately reportable under 97153 (adaptive behavior treatment by protocol administered by technician under the direction of a physician or other qualified health care professional). **Time reported and billed must be face-to-face time with the patient.**

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:

601.3.3. The QHCP is responsible for the delegated work performed by any supervisees.

601.3.4. 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.

601.3.5. 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.

601.3.6. 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.

601.3.7. 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 recordkeeping requirements and providers will be responsible for any additional documentation requested in the event of audits. Records should include:

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

602.3.2. 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.

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

602.3.4. 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. Secure Electronic Signatures are acceptable but must meet

compliance as outlined in the Part I Policies and Procedures for Medicaid/Peachcare for Kids, "Definitions" section.

602.3.5. 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.

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

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

602.3.7.1. Individual's name and/or other information related to their identification (SS#, Medicaid ID, etc…)

602.3.7.2. Date and time of admission

602.3.7.3. Admitting Diagnosis

602.3.7.4. Verified Diagnosis

602.3.7.5. The name, address, and telephone number of the responsible party to contact in an Emergency

602.3.7.6. Appropriate authorizations and consents for medical procedures

602.3.7.7. Medical necessity of the service being provided

602.3.7.8. Results of testing and/or assessments

602.3.7.9. Records or reports from previous or current providers including previous assessments

602.3.7.10. Documented correlation between assessed need and care plan

602.3.7.11. Documentation of treatment that supports billing

602.3.7.12. Financial and insurance information

602.3.7.13. Pertinent medical information

602.3.7.14. Physicians' progress notes

602.3.7.15. Nurses' notes

602.3.7.16. Practitioner and case management notes

602.3.7.17. Clear evidence that the services billed are the services provided

602.3.7.18. Treatment and medication orders

602.3.7.19. Date and time of discharge or death

602.3.7.20. 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:

602.5.1. The regular provider is unavailable to provide the visit services.

602.5.2. The Medicaid Member has arranged or seeks to receive the services from the regular provider.

602.5.3. The regular provider pays the locum tenens for his or her services on a per diem or similar fee-for-time basis.

602.5.4. The substitute provider does not provide services to Medicaid members for a period of time not to exceed sixty continuous days.

602.5.5. The covering provider must be an enrolled Medicaid provider.

602.5.6. The locum tenens should have a valid Medicaid number in the State of Georgia.

602.5.7. Reimbursements will be for services which the regular provider (or group) is entitled to submit.

602.5.8. A provider or other person who falsely certifies any of the above requirements may be subject to possible civil and criminal penalties for fraud.

602.5.9. 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)

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

701.1.1. The member's Medicaid benefits must be active ***on*** the date of service. As outlined in Section 107 of the Part I Policies and Procedures for Medicaid/Peachcare for Kids manual, "It is the responsibility of the provider to verify Medicaid/PeachCare for Kids eligibility on each date of service".

701.1.2. Autism Spectrum Services are for individuals under the age of 21.

701.1.3. Children must be able to participate in sessions.

701.1.4. 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.

701.1.5. 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 and 1 caregiver tool**.

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

701.1.6. Primary hearing deficits

701.1.7. Primary speech disorder

701.1.8. Heavy metal poisoning

701.1.9. 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

Chapter 800: Prior Approval

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. Behavioral Assessment prior authorizations may be requested in 3-month increments and Treatment prior authorizations may be requested in 6-month increments. Initial Behavioral Assessments and Reassessments may be completed one time during the 6-month treatment authorization period (no more than 2 months prior to the effective date of the next treatment authorization).

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:

801.1. Summary of each individual assessment.

801.2. Include the date it was completed and include the tests administered with scores.

801.3. Include the evaluator’s signature, 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:

801.4. Standardized assessment tools specifically utilized to assess ASD or the specific core characteristics present in individuals with ASD

801.5. Robust empirical support for the individual’s age

801.6. Includes diagnostic validity and reliability for this purpose

801.7. Minimum of two (2) assessment tools (1 primary clinician tool and 1 caregiver tool) from the following table:

801.7.1.Approved Assessment Tools

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)
EarliPoint	Parent input via formal tool (screener, rating scale, or clinical interview)
Canvas DX	Parent input via formal tool (screener, rating scale, or clinical interview)
Caregiver Tool	**Other tools needed:**
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
Accepted Non-ASD specific Caregiver tools:	Other tools needed:
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

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

801.8. Provisional diagnosis of Autism Spectrum Disorders (as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders).

801.9. No formal neuropsychological evaluation was completed/conducted

801.10. 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.

802. 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), Essentials for Living, or Skills assessment.

Behavioral Assessments for maladaptive behavior may include functional behavioral assessments, traditional functional analyses, or Interview-Informed, Synthesized Contingency Analysis (IISCAs).

The Behavioral Assessment for skill acquisition and maladaptive behavior should be summarized and used to guide the development of future interventions in the form of a Plan of Care (POC). Scores and graphs alone are insufficient as they lack context regarding the member's current skill levels and needs. The emphasis should be on summarizing performance and outcomes across relevant domains, rather than describing the assessment process itself.

Behavior analysts, with appropriate consent, should conduct record reviews of all available data (e.g., educational, medical, historical, effectiveness of prior interventions, etc..) at the outset of receiving a member from another facility; however, behavior assessment(s) and treatment plans must be developed by the current provider. A behavior analyst should not submit behavior assessments and treatment plans that are the work product of another behavior analyst to obtain a prior authorization. If a member transfers to another provider within the same company during a period covered under an active PA, the behavior analyst receiving the transferred member must review and attest that the treatment plan has been approved.

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

802.1. Diagnostic evaluation

802.2. Letter of Medical Necessity

802.3. Individualized Family Service Plan (if applicable).

802.4. Individual Education Plan (submission of document is optional).

802.5. Previous Hospitalization or out-of-home placement documents (if applicable).

802.6. Medicaid Cover Page (Appendix D)

802.7. Any other clinical documentation needed to support the plan of care as supported by best practices.

803. 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 PA effective date.

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

803.1. Diagnostic evaluation

803.2. Letter of Medical Necessity

803.3. Descriptive results of behavioral assessment as defined in 801.1

803.4. Proposed Plan of Care (POC) –see section 801.2.1 for additional guidance

803.5. Updated data collected during previous treatment authorizations (if not initial request). For continued treatment authorization (non-initial requests), updated data collected during the previous authorization period must be current and aligned with the most recent behavior assessment. For any new goals that were previously baselined but not yet introduced, probe data must be included. This data should reflect the member's current performance and must not be more than two months older than the effective date of the requested prior authorization. This ensures that treatment planning is based on timely and relevant information.

803.6. Individualized Family Service Plan (if applicable).

803.7. Individual Education Plan (submission of document is optional).

803.8. Previous Hospitalization or out-of-home placement documents (if applicable).

803.9. Progress summaries, if applicable, are required for each behavior targeted for reduction. These summaries should address data variability, clarify the effectiveness of current intervention strategies, and describe any modifications implemented. Replacement behaviors identified based on hypothesized functions must be written in goal format to ensure accurate data collection on these skills.

803.10. Medicaid Cover Page (Appendix D)

803.11. Any other clinical documentation needed to support the plan of care as supported by best practices.

Treatment services typically range from 10 to 30 hours per week, though the amount may be higher or lower when medically necessary. Requests exceeding 30 hours per week will undergo an enhanced authorization review. 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.

804. Plan of Care (POC)

The Plan of Care (POC) should demonstrate a clear connection between the results of the behavioral assessment and the specific goals developed for the individual. Goals should target areas identified as needing remediation, with particular emphasis on pivotal, functional skills related to the core deficits of ASD. Each goal must include baseline data, measurement methods, and mastery criteria designed to address the core deficits of ASD, consistent with the practice guidelines for treatment of ASD established by the Behavior Analyst Certification Board (BACB).

A DCH-approved treatment plan template has been added to the manual and is available in Appendix F. While use of the template is not required, the guidance it contains reflects the best-practice standards outlined in the policy and can assist providers in developing treatment plans that align with those expectations.

Treatment for Autism Spectrum Disorder (ASD) must:

804.1. Demonstrate that ABS are not custodial or maintenance-oriented in nature;

804.2. Include coordination across all providers, supports, and resources;

804.3. Identify parent, guardian, and/or caregiver involvement in prioritizing target behaviors and training in behavioral techniques in order to provide additional supportive interventions;

804.4. Include criteria and specific behavioral goals and interventions for lesser intensity of care and discharge;

804.5. Provide evidence that applicable community resources have been identified and engaged;

804.6. Provide evidence/support for a reasonable expectation that the member can benefit from the services proposed.

School plans will be reviewed for medical necessity; therefore, clinical documentation must be clearly outlined to detail the maladaptive behaviors that the member exhibits that requires the need for intensive support services in the school setting. These plans must include the following:

804.7. Target behaviors that are operationally defined with measurable data regarding the frequency, symptom intensity, duration or other objective measures of baseline and current levels.

804.8. Include the days and times when problem behaviors are occurring at a high frequency, intensity, and duration.

804.9. Outline goals related to behavior reduction and functionally equivalent replacement behaviors that are desirable behaviors that achieve the same outcome or meet the same need as a less desirable problem behavior.

804.10. Titration plan that includes a timeline when behavioral conditions qualify the fading out of school services when criteria for progress are established.

804.11. Behavior reduction line graphs tailored for the school setting, designed to comply with the specifications outlined in Appendix D. As part of the clinical review process, any behavioral

interventions implemented in the school setting that were amended or modified during the previous authorization period due to insufficient progress must be clearly identified. These changes should be visually represented using phase change lines within data displays to demonstrate the effectiveness of the revised interventions. This visual documentation supports data-driven decision-making and ensures transparency in treatment adjustments.

804.12. The most recent Individualized Education Plan (IEP), Individualized Family Support Plan (IFSP), and/or 504 plan should be included for members who attend a public school.

When school services are medically necessary, school plans should be accompanied with a treatment plan for services to also occur in either the home and/or clinic setting as treatment in the school setting is limited to the reduction of problem behavior that impede the member's ability to engage in academic tasks and the teaching of functionally equivalent replacement behaviors. Exceptions to services occurring exclusively in the school environment will be evaluated on an individual basis and must be supported with clinical rationale.

Training of School Personnel: To promote consistent coordination of care, it is strongly encouraged that training of school personnel occurs in the presence of the parent or guardian, either virtually or in person. This collaborative approach ensures alignment across home and school environments. When additional school support is medically necessary, providers may request supplemental units of CPT code 97156. These requests should include clearly defined goals specific to the school setting, with a focus on training related to behavioral intervention procedures and the implementation of appropriate replacement behaviors.

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.

902.1.1. 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).

902.1.2. 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.

902.1.3. 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:

902.1.3.1. Access the Division's DCH I newsletter and FAQs at: http://dch.georgia.gov/publications

902.1.3.2. Access the Division's DCH-I newsletter and FAQs at: http://dch.georgia.gov/publications

902.1.3.3. Search to see if a provider is enrolled at: https://www.mmis.georgia.gov/portal/default.aspx

902.1.3.4. Choose the 'Provider Enrollment/Provider Contract Status' option.

902.1.3.5. Enter Provider ID or NPI and provider's last name.

902.1.3.6. 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 may 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	Physician Psychologist BCBA-D BCBA BCaBA RBT

Service	Assessment Description	Authorized Provider Type
	of the Authorized Provider Type's time, face-to-face with the member. Additional (30) minute increments are authorized in accordance with medical necessity.	
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
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	Physician Psychiatrist Psychologist BCBA-D BCBA

Service	Assessment Description	Authorized Provider Type
	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 face-to-face time. Additional (30) minute increments are authorized in accordance with medical necessity.	
Adaptive Behavior Treatment Social Skills Group	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 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.	Physician Psychologist Psychiatrist BCBA-D BCBA 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

903.1. Covered Services by CPT or HCPCs
All services are to be billed with modifiers specific to 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.

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 crosswalk 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	$59.96
		U2	U6	15 mins	$40.14
		U3	U6	15 mins	$30.91
		U1	GT	15 mins	$59.96
		U2	GT	15 mins	$40.14
		U3	GT	15 mins	$30.91
		U1	U7	15 mins	$76.31
		U2	U7	15 mins	$48.16
		U3	U7	15 mins	$37.78
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 minutes	97152	U1	U6	15 mins	$59.96
		U2	U6	15 mins	$40.14
		U3	U6	15 mins	$30.91
		U4	U6	15 mins	$20.91
		U5	U6	15 mins	$15.58
		U1	GT	15 mins	$59.96
		U2	GT	15 mins	$40.14
		U3	GT	15 mins	$30.91
		U4	GT	15 mins	$20.91
		U5	GT	15 mins	$15.58
		U1	U7	15 mins	$76.31
		U2	U7	15 mins	$48.16
		U3	U7	15 mins	$37.78
		U4	U7	15 mins	$25.09
		U5	U7	15 mins	$18.69
Behavior identification supporting assessment, each 15 minutes of technician' time face-to-face with a patient, requiring the following	0362T	U1	U6	15 mins	$59.96
		U2	U6	15 mins	$40.14
		U3	U6	15 mins	$30.91

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		U4	U6	15 mins	$20.91
		U5	U6	15 mins	$15.58
		U1	GT	15 mins	$59.96
		U2	GT	15 mins	$40.14
		U3	GT	15 mins	$30.91
		U4	GT	15 mins	$20.91
		U5	GT	15 mins	$15.58
		U1	U7	15 mins	$76.31
		U2	U7	15 mins	$48.16
		U3	U7	15 mins	$37.78
		U4	U7	15 mins	$25.09
		U5	U7	15 mins	$18.69
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	$59.96
		U2	U6	15 mins	$40.14
		U3	U6	15 mins	$30.91
		U4	U6	15 mins	$20.91
		U5	U6	15 mins	$15.58
		U1	GT	15 mins	$59.96
		U2	GT	15 mins	$40.14
		U3	GT	15 mins	$30.91
		U4	GT	15 mins	$20.91
		U5	GT	15 mins	$15.58
		U1	U7	15 mins	$76.31
		U2	U7	15 mins	$48.16
		U3	U7	15 mins	$37.78
		U4	U7	15 mins	$25.09
		U5	U7	15 mins	$18.69
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	$59.96
		U2	U6	15 mins	$40.14
		U3	U6	15 mins	$30.91
		U4	U6	15 mins	$20.91
		U5	U6	15 mins	$15.58
		U1	GT	15 mins	$59.96
		U2	GT	15 mins	$40.14
		U3	GT	15 mins	$30.91
		U4	GT	15 mins	$20.91
		U5	GT	15 mins	$15.58
		U1	U7	15 mins	$76.31
		U2	U7	15 mins	$48.16
		U3	U7	15 mins	$37.78
		U4	U7	15 mins	$25.09
		U5	U7	15 mins	$18.69
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	$59.96
		U2	U6	15 mins	$40.14
		U3	U6	15 mins	$30.91
		U1	GT	15 mins	$59.96
		U2	GT	15 mins	$40.14
		U3	GT	15 mins	$30.91
		U1	U7	15 mins	$76.31

		U2	U7	15 mins	$48.16
		U3	U7	15 mins	$37.78
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	U1	U6	15 mins	$22.56
		U2	U6	15 mins	$17.52
		U3	U6	15 mins	$13.61
		U1	GT	15 mins	$22.56
		U2	GT	15 mins	$17.52
		U3	GT	15 mins	$13.61
		U1	U7	15 mins	$27.52
		U2	U7	15 mins	$21.40
		U3	U7	15 mins	$17.01
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	$26.10
		U2	U6	15 mins	$17.51
		U3	U6	15 mins	$13.61
		U1	GT	15 mins	$26.10
		U2	GT	15 mins	$17.51
		U3	GT	15 mins	$13.61
		U1	U7	15 mins	$31.90
		U2	U7	15 mins	$21.40
		U3	U7	15 mins	$17.01
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	$26.10
		U2	U6	15 mins	$17.51
		U3	U6	15 mins	$13.61
		U1	GT	15 mins	$26.10
		U2	GT	15 mins	$17.51
		U3	GT	15 mins	$13.61
		U1	U7	15 mins	$31.90
		U2	U7	15 mins	$21.40
		U3	U7	15 mins	$17.01
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 and immediately available to join the session; - 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	$59.96
		U2	U6	15 mins	$40.14
		U3	U6	15 mins	$30.91
		U4	U6	15 mins	$20.91
		U5	U6	15 mins	$15.58
		U1	GT	15 mins	$59.96
		U2	GT	15 mins	$40.14
		U3	GT	15 mins	$30.91
		U4	GT	15 mins	$20.91
		U5	GT	15 mins	$15.58
		U1	U7	15 mins	$76.31
		U2	U7	15 mins	$48.16
		U3	U7	15 mins	$37.78
		U4	U7	15 mins	$25.09
		U5	U7	15 mins	$18.69

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

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

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)

****Review the Telemedicine Guidance policy manual located on GAMMIS for further guidance***

The following providers are authorized to directly deliver ASD services:

<table>
<tr><th>Licensed Physician (with or without BCBA certification)</th><th>Licensed Psychologist (with or without BCBA certification)</th><th>Board Certified Behavior Analyst-Doctoral Level (BCBA-D)</th><th>Board Certified Behavior Analyst (BCBA)</th><th>Board Certified Assistant Behavior Analyst (BCaBA)</th><th>Registered Behavior Technician (RBT)</th></tr>
<tr><td>May be the enrolled QHCP.</td><td>May be the enrolled QHCP.</td><td>May be the enrolled QHCP.</td><td>May be the enrolled QHCP.</td><td>May not be the enrolled QHCP.</td><td>May not be the enrolled QHCP</td></tr>
<tr><td rowspan="3">May supervise the work of BCaBAs and RBTs who implement behavior-analytic interventions.</td><td rowspan="3">May supervise the work of BCaBAs and RBTs who implement behavior-analytic interventions.</td><td>May supervise BCaBAs, RBTs and others who implement behavior-analytic interventions</td><td>May supervise the work of BCaBAs and RBTs who implement behavior-analytic interventions.</td><td>May supervise the work of RBTs.</td><td>Must be supervised by a BCBA/BCBA-D or BCaBA</td></tr>
<tr><td rowspan="2">A doctoral level independent practitioner qualified to provide behavior-analytic services/ direct services.</td><td rowspan="2">A masters/graduate level independent practitioner qualified to provide behavior-analytic services/direct services.</td><td>Bachelor’s level practitioner</td><td rowspan="2">Paraprofessional who implements the service plan under supervision of a BCBA/BCBA-D</td></tr>
<tr><td>Must be supervised by a physician, psychologist, or BCBA/BCBA-D</td></tr>
</table>

Appendix B
Georgia Families, Georgia Families 360, and Non-Emergency Medical Transportation

A. Georgia Families, Georgia Families 360, and Non-Emergency Medical Transportation

For information on the Georgia Families, Georgia Families 360, or Non-Emergency Medical Transportation program, please access the overview document at the following link:

i. **Georgia Families Overview:**
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx

ii. **Georga Families 360 Overview:**
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx

iii. **Non-Emergency Medical Transportation Overview:**
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx

Appendix C
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 observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary 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 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	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-to-face 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 minutes	15 Mins
0361T	Observational behavioral follow-up assessment, each additional 30 minutes of technician time, face-to-face with the patient (list separately 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 minutes	15 mins
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-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	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, administered 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 separately in addition to code for primary procedure	30 mins	97153	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	15 min
0366T	Group adaptive behavior treatment by protocol administered by technician, face-to- face with two more patients; 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 professional, 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 professional, face-to-face with two or more patients, each 15 minutes	15 mins
0368T	Adaptive behavior treatment with protocol modification administered by physician or other qualified 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 qualified healthcare professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes	15 mins
0369T	Adaptive behavior treatment with protocol modification administered 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 qualified healthcare professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes	15 mins
0370T	Family adaptive behavior treatment guidance administered by physician 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 professional (without the patient present) [untimed]	90 mins	97157	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	15 mins
0372T	Adaptive behavior treatment social skills group administered by physician or other qualified healthcare professional face-to-face with multiple patients. [untimed]	90 mins	97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, face-to-face with multiple patients, each 15 minutes	15 mins
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

Appendix D
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 Medical Necessity:_____

Is this member currently enrolled in school/homeschool? Y N **(**If yes, please provide the name of the school/homeschool and the schedule. If no, please indicate why there is no educational placement and the family's plan to have the member enrolled in school. If the member is under age 6 or age 16 or older, please indicate.):

_____

Name of School/Homeschool Program: _____

School Schedule/Modified Schedule:_____

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, IFSP, and/or 504 plan? (submission is **optional *unless school-based services are requested for members enrolled in a public school***) Y N (If yes, please attach the document(s) and provide the rationale supporting your request to provide school-based ABS services below)

_____

****Initial Behavioral Assessment Date Range:** _____

****Consolidated Prior Authorization Request Date Range (*see Appendix E, Section B, xiv, 2 for guidance*)**

Treatment Date Range: _____

Reassessment Date Range: _____

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

CPT Code:	# of hours/week	# of units/week	# of units/3 mths (13 wks) / # of units/6 mths (26 wks)
97151			
97152			
0362T			
97153			
97154*			
97155*			
97156			
97157			
97158*			
0373T			

**Note:* 97155 is a Protocol Modification code; please see below for guidance on the usage of 97155.
Note:* 97154 and 97158 should **not be billed concurrently. If the behavior analyst is joining a group to provide direction to the technician leading the group, 97154/97155 should be reported together. 97158 is intended for instances where the group session is led by the behavior analyst.

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 be 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: A school plan is required for all educational settings to include both public and private schools with exception only applying to daycares or after-school settings unless these services are provided as a provision of IDEA. 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. Please note that training for school personnel is not reimbursable ***unless the parent/guardian is present either in person or virtually.***
0373T: The request for 0373T units is for severe destructive maladaptive behavior and therefore must be accompanied by the following information: a) Detailed plan on the method in which the additional behavior technician(s) are assisting in the implementation of the behavioral interventions outlined in the treatment plan. b) Environmental configurations that will be in place specific to each behavior that has been targeted for reduction. c) Titration plan that includes the reduction of 0373T units and utilization of 97153 units as the goal should be to transition the member to a less intensive model of intervention. The use of this code must include a BCBA who is onsite and immediately available to join the session.
97155: Protocol modification includes but is not limited to: (a) adjustments to specific components of a protocol (e.g., treatment targets, treatment goals, observation and measurement, reinforcers, reinforcer delivery, prompts, instructions, materials, discriminative stimuli, contextual variables); (b) QHP conducts 1:1 direct treatment to observe patient to determine if the protocol components are functioning effectively for the patient or require adjustments; (c) active direction of a technician while the technician delivers a service to a patient to train the technician to implement a new or modified protocol; (d) QHP implementation of the protocol with the patient to determine if changes are needed to improve patient progress or to test a modified protocol.
If you are performing these actions and documenting these actions, then the code is appropriate for use. Documentation of only supervision or documentation of services being performed at a time when the member is not present would not be appropriate.

A. Checklist: Are the following attached?

i. Diagnostic Evaluation (Refer to Section 801.7.1 for additional details on acceptable assessment tools)

1. Diagnostic Evaluation **Requires** One (1) Clinician Tool **and** One (1) Caregiver Tool from the Acceptable Tools List
   Note: While CARS and GARS both have clinician and caregiver versions, only one version may be used; both versions cannot be used in the same evaluation to satisfy this requirement. For example, the use of GARS-3 (clinician) and GARS-3 (caregiver) in the same evaluation requires a separate acceptable caregiver or clinician tool.

Clinician Tool:

___ADOS-2 (Autism Diagnostic Observation Schedule
___GARS-3 (Gilliam Autism Rating Scale)
___CARS 2 ST/HF (Childhood Autism Rating Scale)
___STAT (Screening Tool for Autism
___CSBS (Communication and Symbolic Behavior Scales)
___TELE-ASD-PEDS
___NODA (Naturalistic Observational Diagnostic Assessment)
___DISCO (Diagnostic Interview for Social and Communication Disorders)
___RITA-T (Rapid Interactive Screening Test for Autism in Toddlers
___ADEC (Autism Detection in Early Childhood)
___EarliPoint
___Canvas DX

Caregiver Tool:

___ADI-R (Autism Diagnostic Interview)
___DISCO (Diagnostic Interview for Social and Communication Disorders)
___CARS QPC (Childhood Autism Rating Scale-Parent Questionnaire)
___GARS-3 (Gilliam Autism Rating Scale)
___SCQ (Social Communication Questionnaire)
___MCHAT (Modified Childhood Checklist for Autism in Toddlers
___SRS-2 (Social Responsiveness Scale)
___ASRS (Autism Spectrum Rating Scale)
___ABC (Autism Behavior Checklist)
___TASI (Toddler Autism Symptom Inventory)
___BASC (Behavior Assessment System for Children)
___PDD-BI (PDD-Behavior Inventory)
___PEDS-DM (Parents' Evaluation of Developmental Status)
___ASQ-3 (Ages and Stages Questionnaire)
___ASQ:SE2 (Ages and Stages Questionnaire: Social Emotional)
___CBRS (Conners Behavior Rating Scale)
___CDI (Childhood Development Inventory)
___CSBS DP Infant Toddler Checklist

ii. Letter of Medical Necessity

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

1. Brief background information including demographics, diagnostic history, medical history, living situation, school information (grade, IEP (optional unless school-based services are requested), services receiving, etc.), previous ABA services, current ABA services, etc.
2. Current medications
3. Parent/caregiver concerns
4. Assessment procedures and results (summary, graphs, tables, grids)
5. Skill Acquisition Goals including baseline data, mastery criteria, progress summary
6. Behavior Reduction Goals (if appropriate) including baseline data, operational definition/topography of behavior, treatment strategies to include antecedent and consequence, replacement behaviors, treatment strategies, behavior reduction goal, progress summary, graphs
7. Caregiver Training Goals including baseline data, mastery criteria, etc.
8. Coordination of Care
9. Transition Plan
10. Discharge Criteria
11. Crisis Plan

Supervising BCBA/BCBA-D Signature: _____

Date: _____

Electronic Signatures: Refer to section 602.3.4

Appendix E
Alliant Health Solutions - FFS Autism Therapy Services Prior Authorization

A. 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.

i. **Prior Authorization requests are processed in two phases.**

1. The initial Technical Review phase verifies that all required documentation has been submitted and that such documentation conforms to applicable guidelines. If all required documentation is present, accurate, and compliant, the PA request is advanced to the Peer Review phase.

2. The Peer Review phase evaluates the medical necessity, clinical accuracy, and overall compliance of the documentation with established guidelines. Please note that a technical denial is limited to issues related to missing or non-compliant documentation and does not address medical necessity or clinical content within the PA submission.

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.

B. Autism Therapy Request Guidelines and Restrictions

The PA type for Autism Therapy services is AU;

i. Providers must have COS code of 445 and a Specialty Code of 565 or 566;
ii. Only Applied Behavioral Analysis (ABA) procedure codes may be entered on the request;
iii. Providers submit one PA for assessment codes and one PA for treatment codes;
iv. System validation prevents assessment codes and treatment codes to be entered on the same PA;
v. Requests must have an effective/start date equal to or greater than the request date;
vi. Requests may be submitted up to 2 months before the PA's effective date (for example, a PA starting 6/1/2026 may be submitted as early as 4/1/2026). Before submitting, providers should verify that the effective date they entered is correct to prevent potential overlaps or early PA expiration.
vii. Overlapping treatment PAs are not permitted; however, under the Consolidated Ongoing PA structure, DCH will allow one overlap for reassessment purposes. During this period, the member may have one treatment PA that includes reassessment codes and one additional PA containing assessment-only codes. Coordination between the current and new provider remains essential to ensure continuity of care. To resolve overlapping PA denials, the provider holding the active PA may:

1. **Share the member's active treatment PA** information with the new provider; or
2. **Submit an end-date request (if any billable services were or will be submitted for reimbursement)** via the "change request" option located in the PA Provider Workspace/Medical Review Portal. The request should indicate an effective end-date which should reflect the last date that billable services were rendered.
3. **Submit a request to withdraw the PA (if no billable services were or will be rendered)** via the "change request" option located in the PA Provider Workspace/Medical Review Portal.

If the current provider ends or withdraws their PA, they should notify the parent/guardian once they have submitted the change to Alliant, and, if the PA is end-dated rather than withdrawn, they should also share the end date with the parent/guardian. The parent/guardian can then inform the new provider that the overlapping PA issue has been resolved. If the new provider's PA was denied due to the overlap, they should submit a "contact us" request asking for the PA to be reprocessed. Please note that the new provider may need to adjust their start date if it overlaps with the current provider's end date.

New providers may submit a discharge summary from the previous provider via the "contact us"

option. The summary must be on the prior provider's official agency letterhead and include the supervising BCBA's signature and date. It must clearly list the member's name and Medicaid ID number, specify the service period covered with the effective end date, and provide a summary of the treatment activities completed prior to discharge.

viii. Please allow up to 7 calendar days for the PA request to be reviewed and a decision issued.

If it is necessary for a provider to submit supplemental documentation to resolve a technical or peer denial, an additional 10 calendar days for the reviewer to complete the review and render a decision is required.

ix. All PA requests for all Medicaid members must be approved before services are rendered. Services provided without an approved PA, or provided before the PA effective date, will not be authorized or eligible for reimbursement.

x. PA effective dates cannot be made retroactive or backdated under any circumstance. However, providers may set the PA effective date for up to 30 days prior to the submission date.

xi. Members who are terminated and later reinstated with a retroactive eligibility date do not qualify for a retroactive PA to cover that retroactive eligibility period.

xii. Members who begin services before being approved for Medicaid but later receive retroactive eligibility are not eligible for retroactive prior authorizations. The member must be active on the date of service for a PA to apply. In these instances, providers may use the 30-day backdate flexibility.

xiii. When members transfer from a managed care plan to Fee-for-Service with an approved MCO PA, the PA is eligible for transfer:

1. Submit a new FFS PA request using the same end date as the MCO PA.
    a. Include the documentation that was submitted for the MCO PA request.
2. Indicate that the request is a transfer by selecting the transfer option.
3. Include either the faxed MCO approval letter or the MCO PA number for the PA being transferred, which clearly shows the approved dates of service, CPT codes, and units.

A PA transfer cannot be used to request additional units or different CPT codes. The transfer process only allows the existing authorization to move from the MCO to FFS. Any request for increased units or changes to CPT codes must be submitted separately and will require clinical review.

xiv. **Consolidated Prior Authorization Requirements for Ongoing Assessment and Treatment Services**
To streamline review processes and ensure alignment with updated operational expectations, ongoing prior authorization (PA) requests for Autism Spectrum Disorder (ASD) services must now be submitted as a single, consolidated PA that includes all assessment and treatment codes required for the upcoming authorization period. This consolidation applies to all members who have already completed an initial assessment.

1. The following codes must be submitted together under one ongoing prior authorization:
    a. 97151 - Behavior Identification Assessment
    b. 97152 -Behavior Identification Supporting Assessment
    c. 97153- Adaptive Behavior Treatment by Protocol
    d. 97154- Group Adaptive Behavior Treatment by Protocol
    e. 97155- Adaptive Behavior Treatment with Protocol Modification
    f. 97156- Family Adaptive Behavior Treatment Guidance

g. 97157- Multiple Family Group Adaptive Behavior Treatment Guidance

h. 97158- Group Adaptive Behavior Treatment with Protocol Modification

i. 0362T- Behavior identification supporting assessment; requires QHP on site and assistance of two or more technicians

j. 0373T- Adaptive Behavior Treatment with Protocol Modification, administered by two or more technicians under on-site QHP supervision; used for high-intensity cases involving severe destructive behavior

This consolidated structure ensures that all services provided during the treatment period are reviewed together, consistent with the member's most recent behavioral assessment, treatment plan, and requirements outlined in Sections 801, 802, and 803.

2. Applicability

a. Ongoing/Continued Treatment Requests: Once a member has completed their initial behavioral assessment, the initial treatment PA, and all subsequent ongoing PAs, must be submitted as a single consolidated request. The consolidated submission must include updated behavioral assessment results (dated no more than two months prior to the PA effective date), progress summaries, acquisition and reduction data, updated goals, caregiver training goals, and all requested codes for the full authorization period. Reassessment codes must be entered with an effective date no more than three months before the end of the requested authorization period, and the reassessment itself may not be completed more than two months prior to the start date of the next treatment authorization.

i. Step 1. Initial Assessment Authorization

Assessment codes are authorized to allow the provider to conduct the behavioral assessment that establishes the member's baseline and supports development of the initial treatment plan.

ii. Step 2. Ongoing Combined Assessment and Treatment Authorization

After the initial assessment is completed, the provider may submit an ongoing consolidated authorization that includes both treatment and assessment codes. The ongoing request must follow the required timing structure: treatment codes may cover up to a six-month authorization period, while assessment codes must fall within the final three months of that same period. The behavioral assessment supporting the request must be conducted no more than two months before the start date of the next treatment authorization.

Example

The initial assessment is completed between March 1 and June 1. If the next treatment authorization period runs from June 1 through December 1, the treatment codes would span the full 6-month period. The assessment codes, however, cannot begin earlier than September 1 and must end on, or prior to, December 1.

b. Initial Requests for New Members: For a new member entering the ASD program, or a member who is new to the provider, an initial assessment prior authorization must be obtained. Once the initial assessment is completed, the treatment authorization, and all subsequent ongoing PAs, must be submitted as a single consolidated request.

3. Documentation Requirements for Consolidated Ongoing PAs

a. All consolidated ongoing PA submissions must include the following:

i. Updated Behavioral Assessment Summary - Conducted no more than two months prior to the requested PA effective date, consistent with Section 803.5.

ii. Updated Data Sets - All acquisition and reduction data must reflect the previous

authorization period and must not exceed the two-month threshold. Data older than two months cannot support medical necessity and must be replaced with current probe data.

iii. Progress Summaries - Required for every behavior targeted for reduction, describing variability, intervention effectiveness, and modifications implemented.

iv. Updated Plan of Care - Including measurable goals, mastery criteria, baseline data, replacement behaviors, caregiver goals, and crisis/transition planning as described in Section 804.

v. Service Schedule - One combined schedule reflecting all codes requested, meeting requirements in Appendix D, including confirmation of non-overlapping times and school schedule alignment, when applicable.

4. Rationale and Compliance Expectation

This consolidation requirement aligns ASD services with updated Medicaid operational expectations and supports a more efficient review process under the accelerated seven-day turnaround time. Providers must ensure that all required documentation is complete, accurate, and submitted together at the time of request, as the shortened review period leaves limited opportunity for follow-up or correction. To maintain compliance with policy and avoid unnecessary delays, incomplete submissions or separate submissions for codes that are required to be included within a single ongoing prior authorization will not be accepted. Requests submitted without all applicable assessment and treatment codes, or without the full set of required supporting documents, may result in denial and require the provider to resubmit the entire authorization packet.

C. 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. If the request is denied, you can view the reason by hovering over the 'Denied' status to display the details.

D. Reconsideration Request Guidelines

i. Reconsiderations are allowed when the PA has one or more procedure lines that are:

1. **Approved but not for all units requested** - requests must be submitted within **30** calendar days of the decision.
2. **Peer consultant denied** - requests must be submitted within **30** calendar days of the decision. **Please Note:** ***Providers are only permitted to submit one (1) reconsideration following the first peer denial. If the reconsideration results in a second (2nd) peer denial, the provider must submit a new PA request.***
3. **Tech Denied** but **NOT** Final Tech Denied - Requests must be submitted within **10 calendar days** of the decision. **Please note**: This timeframe does not apply to technical denials issued for overlapping PAs.

If the provider disagrees with the denial or needs clarification, please do not submit a reconsideration. Instead, initiate a peer discussion through the **"Contact Us"** feature in the Provider Workspace portal. This allows the issue to be discussed and resolved, if possible, **before** reconsideration options are exhausted.

ii. 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.

iii. 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 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.

iv. 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 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.

E. 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. Please note that **approved change requests are effective as of the change request submission date and are not valid for any services rendered prior to that date.**

F. 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:

i. **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.

ii. **For a member whose name and Medicaid ID number have 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, GAMMIS will not accept changes made to the PA.

iii. **If a change in modality is requested**, the units to be withdrawn (for substitution) must be specified. This is applicable to PAs for which reconsideration has not been requested.

iv. **To end date or withdraw an active PA.** Refer to Section B of this appendix for additional guidance.

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 PAs 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. To access the existing PA, the new provider will need to obtain the PA information from the provider who requested the PA.

G. PA Submission User Manuals

Autism Therapy PA Submission Instructions

i. Refer to the following User Manuals which are located on GAMMIS at www.mmis.georgia.gov/portal

ii. Select Provider Information

iii. Select Provider Education

iv. Select User Manuals

1. **FFS Autism User Guide** – this guide provides user instructions for submitting and viewing an Autism PA.
2. **Provider Workspace User Manual** – step by step instructions for utilizing the Web Portal Provider Workspace functionality.

Appendix F
Treatment Plan Template

This treatment plan template was developed to support efficient review and ensure alignment with Georgia ASD policy expectations. While use of the template is not required, the guidance it provides should be followed so that submitted documentation reflects the level of detail and structure needed for DCH compliance and timely review.

Client Information

Member Name:

Date of Birth:

Date of Initial Assessment:

Date of Current Reassessment:

Biopsychosocial Information

Family Demographic:

Diagnostic History:

Medications:

Medical History:

School Placement (Include academic schedule, setting, grade, hours/week):

History of ABA Services (Provider name, start/end dates, outcomes):

Other Mental Health Services:

Other Services (OT, SLP, PT, etc.):

Coordination of Care with Other Providers:

Parent Caregiver Concerns:

Narrative

Direct Observation (Home, Clinic, School):

Language/Communication – Strengths and Challenges:

Social Skills - Strengths and Challenges:

Adaptive/Self-Care - Strengths and Challenges:

Challenging Behaviors - Description, Severity Level:

Standardized Assessment Results and Descriptive Analysis

The behavior assessment graph must include the member initials as well as the date in a month/day/year format and must be conducted/dated no more than two (2) months prior to the treatment services PA request effective date. The descriptive results of the behavioral assessments are required for clinical review. Please note that scores alone are insufficient, as they do not provide the necessary context or detail regarding the member's current skill levels and needs related to the assessed domains.

Goal Requirements

Each treatment goal must be measurable, include a defined mastery criterion, specify baseline measurement and projected performance. Progress must be tracked using consistent units, with updated data aligned to the latest assessment. Probe data for new goals, particularly those involving previously baselined but not yet introduced skills, must reflect current performance and be no older than two months. Goals should stem from functional or skills-based assessments, avoid duplication of other services, and exclude vocational content. They should be structured into short- and long-term objectives, with plans for skill maintenance, setting-specific implementation, and identification of replacement behaviors if applicable. The medical necessity rationale must link each goal to core ASD deficits and symptom reduction.

Skill Acquisition Goals

Language/Communication	
Medical Necessity Rationale**:**	
Goal Statement:	
Baseline**:** • **Must be a quantitative measure. (e.g., per hour/week/month, etc.)**	
Date of Introduction**:**	
Projected Mastery:	
Progress Data: • **Measure must match baseline measures (e.g., per hour/week/month, etc.).** • **If applicable, include narrative of any changes in teaching procedures that occurred to assist with acquisition rate**	
Graphs (optional):	

Social	
Medical Necessity Rationale:	
Goal Statement:	
Baseline**:** • **Must be a quantitative measure. (e.g., per hour/week/month, etc.)**	

Date of Introduction:	
Projected Mastery:	
Progress Data**:** • **Measure must match baseline measures (e.g., per hour/week/month, etc.).** • **If applicable, include narrative of any changes in teaching procedures that occurred to assist with acquisition rate**	
Graphs (optional):	

Adaptive/Self-Care	
Medical Necessity Rationale:	
Goal Statement:	
Baseline**:** • **Must be a quantitative measure. (e.g., per hour/week/month, etc.)**	
Date of Introduction:	
Projected Mastery:	
Progress Data**:** • **Measure must match baseline measures (e.g., per hour/week/month, etc.).** • **If applicable, include narrative of any changes in teaching procedures that occurred to assist with acquisition rate**	
Graphs (optional):	

Parent Training Goals

A minimum of two to four documented parent or caregiver training goals is required; mere presence during sessions or general observation does not meet criteria. Goals should focus on applying ABA strategies to reduce maladaptive behaviors and build skills. Include a narrative on progress, barriers with mitigation efforts, and separate goals for group training if requesting units of 97157. All goals must align with ASD related deficits and demonstrate clinical relevance.

Parent Training	
Goal Statement:	
Baseline**:**	
Date of Introduction:	

Projected Mastery:	
Progress Data**:**	
Graphs (optional):	

Group Goals-If applicable

CPT code 97154 must be supported by treatment goals that align with the code's criteria. Group sessions must include at least two participants and may not exceed eight. When 97154 is requested for sessions involving a sibling in the home, the treatment plan must clearly document the clinical rationale and confirm the sibling is an active ABA patient with a current authorization. Requests that include siblings who are not established ABA patients do not meet criteria for 97154. In these cases, services should be billed under 97153, as the session reflects individual treatment for a single authorized member. Codes 97154 and 97158 may not be billed concurrently. When a behavior analyst provides direction to a technician during a group session, 97154 should be billed with 97155. Code 97158 is reserved for group sessions led directly by the behavior analyst. Documentation must support medical necessity and policy compliance.

Group Goals	
Medical Necessity Rationale:	
Goal Statement:	
Baseline**:** • **Must be a quantitative measure. (e.g., per hour/week/month, etc.)**	
Date of Introduction:	
Projected Mastery:	
Progress Data**:** • **Measure must match baseline measures (e.g., per hour/week/month, etc.).** • **If applicable, include narrative of any changes in teaching procedures that occurred to assist with acquisition rate**	
Graphs (optional):	

Behavior Intervention Plan:

In accordance with policy standards, behavioral assessments conducted to evaluate maladaptive behaviors must employ validated methodologies, such as Functional Behavioral Assessments (FBAs), Traditional Functional Analyses (FAs), or Interview-Informed Synthesized Contingency Analyses (IISCAs). Each assessment must include a descriptive summary of findings, specifying the names of all participants, the setting in which the assessment occurred, and the date of administration. Additionally, functionally equivalent replacement behaviors must be presented in goal format, clearly outlining desirable behaviors that serve the same purpose or fulfill the same need as the identified problem behavior.

Behavior Intervention Plan	
Behavior Assessment tool with summary:	
Target Behavior:	

Operational Definition:	
Hypothesized Function:	
Replacement Behavior:	
Antecedent Intervention:	
Consequence Procedures:	
De-escalation Procedures:	

Behavior Reduction Goals	
Medical Necessity Rationale:	
Goal Statement:	
Baseline**:** • **Must be a quantitative measure. (e.g., per hour/week/month, etc.)**	
Date of Introduction:	
Projected Mastery:	
Graphs with Baseline Data and Phase Change Lines (Required):	
Progress Summary: • **Confirm whether current interventions are reducing target behaviors compared to baseline.** • **If not, briefly describe the changes being made.**	
Replacement Behavior Goals and Data:	
Barriers and Intervention Adjustment	

Transition Plan
Transition planning should start at treatment onset and be reviewed regularly. The process must include measurable goals, service adjustments based on progress, and documentation. For school-aged individuals in full-time ABA, school planning is essential. As discharge nears, caregiver training and community resource linkage should increase, with clear criteria such as goal completion, alternative placement, or sustained lack of progress.

Discharge Criteria
Discharge must be clinically justified and based on completion of treatment goals. This phase may also involve transitioning to less intensive services, lack of meaningful progress, or family readiness to maintain gains. Planning should be documented and coordinated with relevant providers or systems, such as schools or community programs.

Crisis Plan
A comprehensive crisis plan should be individualized and developed with the family and care team. The plan must address behavioral triggers, outline de-escalation strategies, and include safety protocols across settings. Clear intervention steps, caregiver training, and post-crisis debriefing are essential. The plan should also cover emergency contacts, readiness for hospitalization, guardianship for adults, and other crises such as medical emergencies, injuries, or severe weather.

Recommendations for ABA Services Supervision typically accounts for 10–20% of direct care hours. Any request exceeding 20% must be supported by a documented medical necessity. Parent or caregiver training must include clearly defined goals and cannot rely solely on session attendance or passive observation. For CPT code 97154, confirm group readiness and provide justification of medical necessity. If telehealth service delivery is requested for any CPT codes, completion of the Telehealth Readiness Checklist is required.	
Medical necessity must reflect the member's core ASD deficits and current functioning in relation to the requested service intensity and location. Include a brief clinical profile that supports the level of care, explaining how ABA services will address symptoms and improve functioning. If requesting changes to service levels, provide specific justification tied to the member's needs.	
Barriers to treatment may include challenges such as home environment disruptions, scheduling conflicts, geographic limitations, staffing shortages, or lapses in service delivery. These factors can impact consistency, engagement, and progress, and should be clearly documented with efforts to address or mitigate them where possible.	

Requested CPT Codes

Units requested should correspond with the table in Appendix D. Use the formula: Hours × 4 units × number of weeks (e.g., 26 weeks = 6 months).

CPT Code	Number of Hours Requested	Total Units	Place of Service
97153	☐ per week ☐ per month		
97154	☐ per week ☐ per month		
97155	☐ per week ☐ per month		
97156	☐ per week ☐ per month		
97157	☐ per week ☐ per month		
97158	☐ per week ☐ per month		
0373T	☐ per week ☐ per month		

Anticipated Schedule

Service schedule should align with the information provided in Appendix D. If sessions occur at multiple locations within the same day, please indicate this clearly in the space provided below.

Code	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
97153							
97154							
97155							
97156							
97157							
97158							
0373T							

Provider Information	
Provider Name:	
Provider Email:	
Provider Address:	
Provider Credentials:	
Provider Signature:	
Date:	

Telehealth Readiness Checklist

Assessment Criteria	Provider Response
Does the member demonstrate basic joint attention skills?	
Does the member demonstrate discrimination abilities?	
Does the member demonstrate echoic abilities?	
Does the member demonstrate motor imitation skills?	
Can the member follow simple one-step instructions?	
Can the member participate in sessions with minimal caregiver assistance?	
Can the member sit independently at a computer for 8–10 minutes?	
Does the member present with low safety risks?	
Are the member's challenging behaviors manageable with caregiver support?	

Georgia ASD School-Based Service Criteria

School-based treatment plans will be reviewed to determine medical necessity. As such, clinical documentation must clearly describe the maladaptive behaviors exhibited by the member that warrants intensive support services within the school setting. To ensure accurate assessment and alignment with policy, all documentation provided in this section must originate exclusively from the school environment, reflecting observations, assessments, and data collected in that context. All requests should include the most recent IEP, IFSP, and/or 504 plan for public school attendees.

Behavior Intervention Plan	
Behavior Assessment tool with summary:	
Target Behavior:	
Operational Definition:	
Days and Times when problem behavior occurs at a high frequency, intensity, and duration.	
Hypothesized Function:	
Replacement Behavior:	
Antecedent Intervention:	
Consequence Procedures:	
Descalation Procedures:	
Transition Plan:	
Training of School Employees: • **Instruction must occur with parent/guardian present (virtually or in person).** • **Requests for CPT code 97156 must include goals specific to school setting and focus on behavioral intervention procedures.**	

Behavior Reduction Goals	
Medical Necessity Rationale:	
Goal Statement:	
Baseline**:** • **Must be a quantitative measure. (e.g., per hour/week/month, etc.)**	
Date of Introduction:	
Projected Mastery:	
Graphs with Baseline Data and Phase Change Lines (Required):	
Progress Summary: • **Confirm whether current interventions are reducing target behaviors compared to baseline.** • **If not, briefly describe the changes being made.**	
Replacement Behavior Goals and Data:	
Barriers and Intervention Adjustments:	