MEDICAL POLICY STATEMENT
Georgia Medicaid

Policy Name & Number	Date Effective
Applied Behavior Analysis for Autism Spectrum Disorder-GA MCD-MM-0212	01/01/2025
Policy Type	
MEDICAL	

Medical Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Applied Behavior Analysis for Autism Spectrum Disorder

B. Background

The *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Text Revised (DSM-5-TR)* classifies Autism Spectrum Disorder (ASD) as a neurodevelopmental disorder varying widely in severity and symptoms, depending on the developmental level and chronological age of the individual. ASD is characterized by specific developmental deficits that affect socialization, communication, academic, and personal functioning. Individuals are typically diagnosed before entering grade school, and symptoms are noticed across multiple contexts, including social reciprocity, nonverbal communicative behaviors, and skills in developing, maintaining, and understanding relationships. Restricted, repetitive patterns of behavior, interests, or activities are also often present.

Currently, there is no cure for ASD, nor is there any single treatment for the disorder. The diagnosis may be managed through a combination of therapies, including behavioral, cognitive, pharmacological, and educational interventions with a goal of minimizing the severity of ASD symptoms, maximizing learning, facilitating social integration, and improving quality of life for members and families/caregivers. Applied behavior analysis (ABA), one such therapy, may be provided in centers or at home and provides an evidence-based practice for the treatment of ASD.

ABA is based on the science of behavior, which was founded on the premise that understanding behavior functioning, how it is affected by the environment, and how learning to change behavior can improve the human condition. It is a flexible treatment in that it should always be adapted to the needs of the individual, teaches skills that are useful and generalizable, and involves individual, group and family training. Qualified and trained practitioners provide and/or oversee ABA programs and are accountable to state boards for registration, certification, or licensure requirements. Clinical decisions on telehealth service delivery models should be selected based on the individual needs, strengths, preference of service modality, caregiver availability and environmental support available.

CareSource follows the Georgia Department of Community Health (DCH) Division of Medicaid and applicable state and federal laws in the provision of ABA services, which are based on a diagnosis from the *DSM-5-TR.* Severity levels are divided into 2 domains and are defined as follows:

Severity Levels for Autism Spectrum Disorder		
Severity Level	Social Communication	Restricted, Repetitive Behaviors
Level 3 – “Requiring very	Severe deficits in verbal & nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions,	Inflexibility of behavior, extreme difficulty coping with change, or other restricted/ repetitive behaviors markedly interfere with

substantial support"	and minimal response to social overtures from others.	functioning in all spheres. Great distress/difficulty changing focus or action.
Level 2 – "Requiring substantial support"	Marked deficits in verbal and nonverbal social communication skills, social impairments apparent even with supports in place, limited initiation of social interactions, and reduced or abnormal responses to social overtures from others.	Inflexibility of behavior, difficulty coping with change, or other restricted/ repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.
Level 1 – "Requiring support"	Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions and clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions.	Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

Social skills instruction is an important component of management of the diagnosis. Although additional studies are necessary, a 2012 meta-analysis of five randomized trials (196 participants) found evidence that participation in social skills groups improved overall social competence and friendship quality in the short term. A 2020 study demonstrated efficacy of a modified group cognitive behavioral therapy program in children delivered in a community context. A 2021 study demonstrated benefits of group cognitive behavioral treatment in adolescents diagnosed with autism and intellectual disabilities. As children near entry in a public or private school system, research supports the use of group therapy for school readiness and improved social skills. Training must be an integral component of the management of the underlying disorder and include clearly defined goals, teach desired behaviors, provide prompting for natural display of desired behaviors, provide reinforcement of demonstrated behaviors, and include practice of desired behaviors with goals of generalizability outside the therapeutic setting (eg, impairments in social-emotional reciprocity, restrictive or obsessional interests, aggressive behaviors).

As the child becomes eligible for school-based services (the age varies depending upon the state), the public school system becomes responsible for the provision of services and education. The services provided are outlined in an individualized education program (IEP), which is reviewed at a minimum of once a year, for children eligible. DCH reiterates that ASD services do not include education services otherwise available through a program funded under 20 US Code 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, Every Student Succeeds Act, in December 2015.

C. Definitions

- **Applied Behavior Analysis** – The design, implementation, and evaluation or systematic instructional and environmental modifications by a behavior analyst to produce socially significant improvements in behavior.
- **Behavioral Assessment** – Separate from the initial diagnostic evaluation, the administration of an industry-standard assessment tool for skill acquisition and/or behavior reduction required to substantiate future treatment services.
- **Caregiver/Family Training** – Training taught by a therapist to parents/caregivers on how to implement methods utilized in a clinical setting into other environments, such as the home or community, to maximize outcomes furthering generalization of skills, and maximizing and reinforcing methods being taught.
- **Direction** – Includes, but is not limited to, the QHCP observing implementation of a member's protocols with member and providing instructions and corrective feedback as needed and/or demonstrating correct implementation of a new or modified protocol with the member while the QHCP observes and provides feedback.
- **Plan of Care (POC)** – A document submitted for authorization of treatment services that includes member goals, background, parent/caregiver training and other criteria associated with treatment.
- **Qualified Health Care Professional (QHCP)** – An individual licensed, certified, or permitted to provide ASD services and enrolled with Georgia Medicaid, including physicians, psychologists, BCBA-D, or a BCBA.
- **Supervision** – The direct clinical review, for the purpose of training or teaching, by a physician, psychiatrist, BCBA-D, or BCBA to promote the development of the practitioner's clinical skills and may include, without being limited to, the review of case presentations, audiotapes, videotapes, and direct observation.

D. Policy

I. General Guidelines

The member's treatment record (eg, plans of care, treatment plans, behavior support plans, functional assessments, daily services notes, progress notes) must be completed by the provider or practitioner, signed by the parent or legal guardian (if minor age) or by the member if applicable and submitted to CareSource prior to claims submission. Claims will not be accepted without accompanying signed treatment documentation.

A. Medical review must be submitted with appropriate documentation as indicated in this policy and align with the State's definition of medical necessity including that treatment is not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results. Along with this policy, CareSource utilizes the following resources for the provision of ABA therapy:
   1. Autism Spectrum Disorder Services Manual provided by Georgia Department of Community Health – Division of Medicaid
   2. MCG Health

B. The following providers are authorized to deliver ABA services:

1. Licensed physician – may supervise BCaBAs and RBTs
2. Licensed psychologist – may supervise BCaBAs and RBTs
3. Board Certified Behavioral Analyst – Doctoral Level (BCBA-D) – may supervise BCaBAs, RBTs and other implementing ABA interventions
4. Board Certified Behavior Analyst (BCBA) – may supervise BCaBAs and RBTs
5. Board Certified Assistant Behavior Analyst (BCaBA) – must be supervised by a physician, psychologist, or BCBA/BCBA-D but may supervise RBTs and may not be the enrolled QHCP
6. Registered Behavior Technician – must be supervised by a BCBA/BCBA-D or BCaBA and may not be the enrolled QHCP

C. Eligibility
1. Member is under the age of 21 and must be able to participate in sessions.
2. Behaviors must be exhibited and present as clinically significant health or safety risks to self or others or significantly interfere with basic selfcare, communication, or social skills.
3. Parent/caregivers must be able to participate in ABA therapy and have the ability to implement ABA techniques in the home environment. If unwilling or unable, consideration will be given to other modalities of treatment.

D. Diagnostic Evaluations

Evaluations should be comprehensive with multiple informants, covering multiple domains, and completed prior to requesting prior authorizations (PAs) for behavioral assessment or treatment services. Primary hearing deficits, speech disorder, and heavy metal poisoning must be ruled out as causal reasons for behavior. The following guidelines apply to diagnostic evaluations:

1. Documentation must be established by the following practitioner:
   a. licensed physician or psychologist
   b. other licensed professional as designated by Medical Composite Board
2. Completion of 1 acceptable evidence-based tool and 1 caregiver tool (a list can be located in the *Georgia Autism Spectrum Disorder Services Policies and Procedures Manual*).
3. Initial evaluation results should be submitted in report format with a summary of each individual evaluation instrument, developmental history, and present concerns, include the following information:
   a. date completed
   b. minimum of 2 assessment tools, including 1 clinician tool and 1 caregiver tool with a summary of each individual assessment
   c. any tests administered with scores
   d. evaluator's name, signature, and credentials

E. Diagnostic Reevaluations

A diagnostic reevaluation, which must include, at a minimum, 1 clinician observational assessment (school psychoeducation assessments are not acceptable), that reconfirms the diagnosis may be required in certain conditions as outlined in the *Georgia Autism Spectrum Disorder Services Policies and Procedures Manual*, including the following:

1. The diagnosis of ASD is provisional.
2. No formal neuropsychological evaluation was completed.
3. The initial diagnosis is at least 5 years old with no evidence of ongoing assessment and treatment.

II. Authorization of Services

CareSource considers ABA services, both the behavioral assessment and treatment services, medically necessary when the following criteria are met. Service authorizations are to be completed separately:

A. Behavioral Assessment (BA) Prior Authorization (PA)
   1. Authorization may be requested in 3-month increments and 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.
   2. PA must be requested by the enrolled QHCP.
   3. The BA is conducted by an independent practitioner who also develops a treatment plan before services are provided. Comprehensive BAs are not to exceed 8 hours every 6 months unless additional justification is provided.
   4. BA will assess the following:
      a. skill acquisition, which may include:
         01. Verbal Behavior Milestones and Assessments Placement Program (VB-MAPP)
         02. Assessment of Basic Language and Learning Skills-Revised (ABLLS-R)
         03. Assessment of Functional Living Skills (AFLS)
         04. Promoting the Emergence of Advanced Knowledge Generalization (PEAK)
         05. Skills assessment
      b. maladaptive behavior, which may include:
         01. functional behavioral assessments
         02. traditional functional analyses
         03. Interview-Informed Synthesized Contingency Analysis (IISCAs)
   5. Summarized results will be used to develop interventions in the form of a plan of care (POC), a required document for treatment service authorization.
   6. Behavior analysts with appropriate consent should conduct record reviews of available data upon receiving members from other facilities; however, BAs and treatment plans must be developed by the current provider.
      a. A behavior analyst should not submit BAs and treatment plans that are the work product of another behavior analyst to obtain a PA.
      b. 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.
   7. Authorization request documentation should include the following:
      a. diagnostic evaluation
      b. Letter of Medical Necessity (LMN)

c. individualized Family Service Plan, if applicable
d. Individual Education Plan (IEP), if applicable
e. previous hospitalization or out-of-home placement documents, if applicable
f. Medicaid Cover Page (see *Georgia Autism Spectrum Disorder Services Policies and Procedures Manual*)
g. any other clinical documentation needed to support the plan of care as supported by best practices (eg, behavioral, psychological or medical history, evidence of previous therapies with results, history of symptom intensity that demonstrates how the member's ability to function in various setting is impacted)

B. Treatment Services Prior Authorization (PA)
1. Authorization may be requested in 6-month increments.
2. Documentation should include the following:
a. diagnostic evaluation
b. Letter of Medical Necessity (LMN)
c. descriptive results of the BA, conducted/dated no more than 2 months prior to the treatment services PA effective date
d. proposed Plan of Care (POC)
e. updated data collected during previous treatment authorizations, if not initial request
f. individualized Family Service Plan, if applicable
g. Individual Education Plan (IEP), if applicable
h. previous hospitalization or out-of-home placement documents, if applicable
i. progress notes, if applicable
j. Medicaid Cover Page (see *Georgia Autism Spectrum Disorder Services Policies and Procedures Manual*)
k. any other clinical documentation needed to support the POC as supported by best practices
3. Medical necessary will determine approved hours per week (eg, typically 10-30 hours) but should be commensurate with skill deficit or behavioral excesses as identified in the BA.
4. Active parent/caregiver participation and involvement is required to increase behavior improvement in behaviors identified as causing limitations or deficits in functional skills.

C. Follow-up service PA requests, following the initial treatment PA, must include the following:
1. a summary of previous goals and progress
2. results of a recent BA within the previous 2 months, including any graphs and current measurements
3. individualized goals for the member and parent/caregivers as described in the practice guidelines for treatment of ASD developed by the Behavior Analyst Certification Board (BACB)

III. Plan of Care (POC)

The POC must be submitted for review, be signed by the parent/caregiver and authorization of treatment services and must comply the following provisions:

A. It should include a clear connection between the results of the BA to specific goals developed for the member.
B. Goals should highlight areas in need of remediation, focusing on functional skills related to core deficits of ASD.
C. Baseline data, measurement and mastery criteria should be included and address core deficits as described in the practice guidelines for treatment set forth by the BACB.
D. Treatment must
    1. demonstrate that interventions are not custodial or maintenance-oriented in nature
    2. include coordination across all providers, supports, and resources, particularly that applicable community resources have been identified and engaged
    3. include criteria and specific behavioral goals and interventions for lesser intensity of care and discharge
    4. identify parent, guardian, and/or caregiver involvement in prioritizing target behaviors and training in behavioral techniques to provide additional supportive interventions
    5. provide evidence/support for reasonable expectation that the member can benefit from services provided

IV. Parent/Caregiver Training

Training will evolve as goals are met. Parent/caregiver(s) must actively work on at least one unmet goal with the provider documenting and tracking 2-4 goals. The plan of care must include documentation of the following:

A. understanding/agreement to comply with the requirements of treatment
B. how the parent/caregiver(s) will be trained in skills generalizable to the home and other environments, how the treatment goas are addressed when providers are not present, and overall skill abilities
C. methods by which the parent/caregiver(s) will demonstrate trained skills (presence during sessions is not sufficient for a goal or method of training)
D. barriers to parent involvement and how those are being addressed (eg, parents having the skills to assist with generalization of skills developed by the member)
E. training and time involvement, including any materials or meetings occurring on a routine basis

V. Discontinuation of ABA Therapy

Titration and/or discontinuation of ABA therapy should occur when the following conditions are met (not an all-inclusive list):

A. Treatment ceases to produce significant meaningful progress or maximum benefit has been reached.

B. Member behavior does not demonstrate meaningful progress for two successive 6-month authorization periods as demonstrated via standardized assessments.
C. ABA therapy is making symptoms, behaviors or impairments worse.
D. Symptoms have stabilized, allowing member transition to a less intensive type of treatment or level of care to manage symptoms.
E. Parent/caregiver(s) have refused treatment recommendations, are unable to participate in the treatment program, and/or do not follow through on treatment recommendations to an extent that compromises the effectiveness of the services for member progress.

VI. Documentation Requirements

The State of Georgia and DCH enacts code and establishes guidelines related to requirements for documentation expectations for client records maintained for third party billing. Each dated entry in the professional record is maintained for a period of not less than 5 years after the last date of service or not less than the length of time required by other regulations if longer, including those outlined by Centers for Medicare and Medicaid Services (CMS) and Health Insurance Portability and Accountability Act (HIPAA). All written, electronic and other records will be stored and disposed of in such a manner as to ensure confidentiality. DCH outlines the following minimum standards for records, including:

A. complete medical file with sufficient information to validate the diagnosis and establish the basis for treatment, including, at a minimum, the following:
    1. member name or other information related to identification (eg, social security number, medicaid identification number, date of birth)
    2. date and time of admission
    3. admitting, and then, verified diagnosis
    4. name, address, telephone number of emergency contact
    5. appropriate authorizations and consents for procedures and treatment
    6. medical necessity of the service(s) being provided
    7. results of any testing and/or assessments, including previous testing
    8. records or reports from previous or current providers
    9. documented correlation between assessed need and care plan
    10. documentation of treatment that supports billing and clear evidence that the services billed are the services provided
    11. financial and insurance information
    12. pertinent medical information with physician, nursing, other practitioner, and case management progress notes
    13. any treatment and medication orders
    14. date and time of discharge or death and/or condition on discharge
B. plan of care that includes clear and specific coordination with all providers involved in treatment with individualized expectations and the following:
    1. individualized expectations
    2. prescribed services
    3. service frequency
    4. scope and duration of treatment

5. measurable goals to be achieved

C. progress notes that are legible, detailed, complete, signed and dated, including
   1. signatures must be legible, original, and belonging to the person creating the signature
   2. if illegible, the name should be printed as well as signed
   3. signatures must be dated the actual date signed
   4. rubber stamps are not acceptable but electronic signatures are acceptable in certain circumstances (see *Part I Policies and Procedures for Medicaid/Peachcare for Kids*, Section 106, General Conditions of Participation)

D. corrections 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 or any such product is unacceptable)

E. back-dated records are not allowed, as records should be documented in 'real-time'

VII. Codes of Conduct

Codes of conduct exist to meet credentialing needs of professionals but also function to protect members by establishing, disseminating, and managing professional standards. Additionally, the State of Georgia mandates requirements for providers within the profession to comply with and train in standards and ethics. CareSource supports professional standards established by licensing and credentialing bodies, and therefore, encourages professional compliance to any and all standards across disciplines for the protection of members and families. The ethics code written by the BACB includes the following standards (not all-inclusive):

A. Family oversight must occur by/with the BCBA or BCaBA. An RBT may be present during a family training session to provide assistance with interventions, but the training or supervision of interventions cannot be completed by the RBT.

B. Providers will create a contract for consent to services (eg, "Declaration of Professional Practices and Procedures") at the onset of services that defines and documents, in writing, the professional role with relevant parties.

C. Appropriate effort will be made to involve members and stakeholders in treatment, including selecting goals, designing assessments and interventions, and conducting continual progress monitoring.

D. Providers will identify and address environmental conditions (eg, behavior of others, hazards to client or staff) that may interfere with service delivery, including the identification of effective modifications to interventions and appropriate documentation of conditions, actions taken, and eventual outcomes.

E. Continuity of services will be facilitated to avoid interruption or disruption of services for members, including documentation of actions taken and eventual outcomes.

F. Providers will address any possible circumstances when relevant stakeholders are not complying with the behavior-change intervention(s) despite documented and appropriate efforts to address barriers to treatment.

VIII. Supervision Expectations

The State of Georgia and DCH enacts codes and guidelines with requirements for supervision and documentation. The QHCP must supervise non-enrolled practitioners under the enrolled provider identification number of the QHCP and/or facility. However, supervision must be performed in accordance with the supervision guidelines of the BACB. Supervision is not separately reimbursable as it is build into the direct service code rates. Time reported and billed MUST be face-to-face time with the patient. QHCP billing of protocol modification is not appropriate in instances when documentation supports only supervision or services being performed at a time when the member is not present. If there are any discrepancies with supervision documentation, the associated claims are subject to recoupment. At a minimum, supervision must include the following and records maintained by the supervisor and supervisee to be submitted for auditing upon request:

A. GA DCH requirements (at a minimum):
    1. duration and type of supervision session
    2. brief summary of pertinent activity for each session
B. The BACB outlines the following minimum provisions for supervision documentation:
    1. RBTs must document the following during supervision (not all-inclusive):
        a. days and times behavior-analytic services were provided
        b. dates and duration of supervision
        c. supervision format (individual, group)
        d. dates of direct observation
        e. names of supervisors providing supervision
        f. noncertified RBT supervisor form, if applicable
        g. proof of supervisor's relationship to the client
        h. additional documentation in the event of discrepant records (session notes)
    2. Supervisors must document the following for any supervision hours conducted (not an all-inclusive list):
        a. date with start and stop times
        b. fieldwork type
        c. supervision type (group, individual)
        d. activity category (restricted or unrestricted)
        e. summary of supervision activity, including
            01. discussion of activities completed during independent hours and any feedback provided
            02. progress toward individual member goals
            03. outcome of supervision, including any modification to treatment interventions or plans of care
            04. collaboration of care among providers
        f. dated signatures of supervisor and supervisee, including credentials
    3. Observations must include the following (at a minimum):
        a. date with start and stop times
        b. fieldwork type

c. setting name
d. supervisor name
e. activity category (restricted or unrestricted)

C. QHCPs are required to follow DCH guidance regarding delegation of work, including the following:
   1. QHCPs are responsible for all delegated work performed by any supervisee.
   2. QHCPs will not delegate professional responsibilities to a person not qualified to provide those services. Responsibilities, even with appropriate levels of supervision, must be within the supervisees' scopes of practice.
   3. QHCP must have education completion and training on supervision rules, professional ethics, standards of practice, and certification guidelines.
   4. QHCPs are responsible for determining competency of supervisee and will provide specific instructions regarding limits of the supervisee's role.
   5. Any QHCP contracts for independent contractors must maintain compliance with DCH policies, including Medicaid enrollment requirements.

D. GA DCH supports BACB published ethical codes related to supervision for the provision of services to clients, including, but not limited to
   1. Behavior analysts are knowledgeable about and comply with all applicable supervisory requirements (eg, BACB rules, licensure requirements, funder and organization policies), including those related to supervision modalities and structure (eg, in person, video conference, individual, group).
   2. Behavior analysts supervise and train others only within an individual identified scope of competence.
   3. Behavior analysts take on only the number of supervisees that allows effective supervision and training. When a threshold volume for providing effective supervision has been met, documentation of this self-assessment and communication of results to employer(s) and relevant parties must occur.
   4. Behavior analysts are accountable for supervisory practices and professional activities (eg, client services, supervision, training, research activity, public statements) of supervisees occurring as part of that relationship.
   5. Behavior analysts ensure that documentation, and the documentation of supervisees or trainees, is accurate and complete.
   6. Behavior analysts deliver supervision and training in compliance with applicable requirements (eg, BACB rules, licensure requirements, funder and organization policies) and design and implement supervision and training procedures that are evidence based, focus on positive reinforcement, and are individualized for each supervisee and circumstances.
   7. Behavior analysts actively engage in continual evaluation of supervisory practices using feedback from others and client and supervisee outcomes. Self-evaluations are documented and timely adjustments made to supervisory and training practices as indicated.

IX. Special Provisions Related to RBTs
   A. Current Standards for RBTs

1. RBT services must be supervised by a qualified RBT supervisor (BCBA, BCBA-D, or BCaBA). RBTs may not be the enrolled QHCP and must obtain ongoing supervision for a minimum of 5% of the hours spent providing ABA services per month. Additionally, the BACB publishes information regarding the structure of supervision and parameters for group and individual supervision in the *RBT Handbook*.
2. An RBT certified by the BACB may provide ABA under the supervision of an independent practitioner if enrolled in the Medicaid program and affiliated with the organization under which the provider is employed or contracted. If the independent practitioner leaves the affiliated organization and no longer provides supervision, the RBT may not continue to provide services under that independent practitioner. Additionally, if the RBT leaves the affiliated organization and no longer receives mandated supervision, the RBT may not continue to provide services to the member.
3. RBTs must use appropriate modifiers that indicate qualifications of staff delivering services.

B. Upcoming RBT Changes from the Behavior Analyst Certification Board

1. **Effective January 1, 2026**: In the interest of consumer protection, the BACB Board of Directors approved a recommendation that RBT supervisors must hold BCBA or BCaBA certification. Noncertified supervisors will not be allowed to provide BACB-required supervision to RBTs. During this transition, RBT Requirements Coordinators who currently attest to the qualifications of noncertified supervisors should make preparations to ensure continuity of care for clients.
2. **Effective January 1, 2026**: New rules regarding eligibility for and maintenance of certification for RBTs were adopted by the BACB Board of Directors and can be located in the BACB Newsletter: December 2023 at www.bacb.com.

X. Telehealth Guidance

The provision of ABA services is allowed via telehealth per GA DCH. *Part II Policies and Procedures for Autism Spectrum Disorder Services* publishes applicable codes, modifiers and allowable provider types. Additionally, *Part II Policies and Procedures for Telehealth Guidance* provides information for telehealth billing requirements, which is only billable if the provider is in GA or within 50 miles of the GA border when services are rendered.

Providers utilizing telehealth for the delivery of services must make decisions that are consistent with best, currently available evidence and clinical consensus. Clinical rationale must consider assessed needs, strengths, preferences, and available resources of members and caregivers. The same professional ethics governing in-person care must be followed and limitations considered, including interstate licensure challenges, state regulatory issues, member or caregiver discomfort with technology, technology limitations, and cultural acceptance of virtual visits. Providers must identify protocols for clinical appropriateness (eg, risk assessment, safety

planning, patient/caregiver characteristics), ensure therapeutic benefit for recipients, and ensure provider competence of delivering care via telehealth modalities. Peer reviewed studies and other best evidence literature provides guidance on appropriate screeners and questionnaires for use in the determination of appropriateness of telehealth services for particular clients.

XI. Exclusions

ABA is not covered in the following circumstances:

A. rehabilitative services (eg, community psychiatric supportive treatment, therapeutic behavioral service, and psychosocial rehabilitation service) for the provision of ABA
B. reimbursement is not permitted under any of the following situations:
    1. any services not documented in the treatment plan
    2. behavioral methods or modes considered experimental
    3. educational-related services or activities described under Individuals with Disabilities Education Improvement Act of 2004, 20 U.S.C. 1400 (IDEA), amended through Public Law 114-95, the Every Student Succeeds Act
    4. vocational services in nature or those available through programs funded under Section 110 of the Rehabilitation Act of 1973
    5. components of adult day care programs
C. treatment solely for the benefit of the family, caregiver or therapist
D. treatment solely focused on recreational or educational outcomes
E. goals focused on academic targets (eg, treatment should address autistic symptoms impeding deficits in the home environment, such as reduction of frequency of self-stimulatory behavior to follow through with toilet training or completing a mathematic sorting task)
F. treatment unexpected to cause measurable, functional improvement or improvement is not documented
G. duplicative therapy services addressing the same behavioral goals using the same techniques as the treatment plan, including services under an IEP
H. services provided by family or household members
I. care primarily custodial in nature and not requiring trained/professional ABA staff
J. shadowing, para-professional, or companion services in any setting
K. personal training or life coaching
L. services more costly than an alternative service(s), which are as likely to produce equivalent diagnostic or therapeutic results for the member
M. programs or services performed in nonconventional settings, even if performed by a licensed provider, including spas/resorts, vocational or recreational settings, Outward Bound, and wilderness camp or ranch programs

E. Conditions of Coverage

I. Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis, subsequent medical review audits, recovery of overpayments identified, and provider prepay review.

II. When a member has other insurance, Medicaid is always the payer of last resort. CareSource will not pay more than the Medicaid rate totals for service. The primary payer must provide evidence of determinations for consideration of Medicaid coverage for services.

III. CareSource reserves the right to request supervision documentation.
   A. Level 4 and 5 practitioners work under the supervision of higher-level practitioners. Providers are required to bill at the appropriate practitioner level and service code for the service rendered. To enroll as a Medicaid provider, the provider must either physically be located in Georgia or located within 50 miles of the Georgia border.
   B. Adaptive behavior treatment with protocol modification administered by an authorized provider type (ie, physician, psychiatrist, psychologist, BCBA-D, BCBA) with 1 client for the first 30 minutes utilizes patient face-to-face time. Additional 30-minute increments requirement authorization in accordance with medical necessity.

IV. Providers agree to bill Medicaid for only those services rendered by the provider or by a Qualified Health Professional under the provider's direct supervision. Under no circumstances may a provider bill for services rendered by another practitioner who is enrolled or eligible to enroll as a provider. All services are to be billed with modifiers specific for practitioner level and service delivery setting/modality, as follows:

Practioner	Level Legend
Physician, Psychiatrist	U1 – Level 1
Psychologist, BCBA-D	U2 – Level 2
BCBA	U3 – Level 3
BCaBA	U4 – Level 4
RBT	U5 – Level 5

V. Providers agree to bill Medicaid the procedure code(s) which best describes the service rendered and not to bill under separate procedure codes for services included under a single procedure code. Coding of both diagnoses and procedures is required for all claims and must be to the highest level.

VI. Providers cannot submit multiple dates of service on a single claim line. Each claim line must be specific to a single date of service and the units provided on that single date of service.

VII. Both codes and modifiers can be found in the *Georgia Autism Spectrum Disorder Services Policies and Procedures Manual.* The maximum daily units per procedure code as mandated by CMS and published by the State of GA is as follows:

Procedure Code	Max Units Per Day
97151	32

97152	16
97153	32
97154	18
97155	24
97156	16
97157	16
97158	16
0362T	16
0373T	32

F. Related Policies/Rules
   I. CareSource Documents
      A. Medical Necessity Determination Standards
      B. Behavioral Health Service Record Documentation Standards

   II. Other Sources
      A. Health Insurance Portability and Accountability Act (HIPAA) of 1996
      B. Diagnostic, screening, preventive, and rehabilitative services, 42 C.F.R. § 440.130(c) (2023)
      C. Definitions, 42 U.S.C. 1396d (2019)

G. Review/Revision History

	DATE	ACTION
Date Issued	11/29/2017	
Date Revised	04/19/2018	Addition of “qualified healthcare profession” re: final diagnosis criteria. Section III. Diagnosis
	04/01/2020	Updated policy. Annual review.
	04/28/2021	Updated medical necessity criteria, exclusions, discontinuation criteria, and added in language from GAMMIS. Clarified documents referenced. Title change
	12/01/2021	Removed telehealth exclusion Changed assessment from 3 to 5 years; removed Appendix G; added note D.2.k.
	04/27/2022	Updated definitions. Reorganized. Approved at Committee.
	04/12/2023	Annual review. Expanded background. Added sections VII-X.
	03/13/2024	Added sections VII – X & MUE information to Cond of Coverage section. Updated H. Approved at Committee.
	04/24/2024	Added II.A.5. GAMMIS update 4/1/24. Approved at Committee.
	07/31/2024	Added direction (GAMMIS update 7/1/24), D.III.E., VIII.D., IX.A.1.a.-b., X., E.III.A-C., updated references. Approved at Committee.
	09/25/2024	Out of cycle review. Added documentation submission prior to claim submission.
Date Effective	01/01/2025	

Date Archived		

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