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May 31, 2017

MEMORANDUM

MEMO NOS. (Re-issued)
Revised QI-1708
Revised FFS 17-03
[Replaces QI-1515,
FFS 15-10 dated
08/28/15]

TO: QUEST Integration (QI) Health Plans,
Physicians, Advance Practice Registered Nurses (APRNs), Behavioral Health Providers, and Developmental Disabilities/Intellectual Disabilities (DD/ID) Providers

FROM: Judy Mohr Peterson, PhD
Med-QUEST Division Administrator

SUBJECT: COVERAGE OF INTENSIVE BEHAVIORAL THERAPY (IBT) FOR TREATMENT OF CHILDREN UNDER 21 YEARS OF AGE WITH AUTISM SPECTRUM DISORDER (ASD)

The Department of Human Services, Med-QUEST Division (MQD) is re-issuing this memorandum in its entirety as reference to previously replaced Memorandum numbers were incorrect and Appendix D was not included. There are NO changes to the content except Appendix D has now been attached. There are no changes to Appendices A, B or C and remain the same as the original Memo Number QI-1708/FFS 17-03 that was dated April 3, 2017. This memorandum provides clarifying guidance regarding coverage of Applied Behavior Analysis (ABA) for the treatment of autism spectrum disorder (ASD) as it relates to other State organizations. In addition, Attachment A, was revised by MQD in December, 2016 but issued at the time the April 3, 2017 memorandum was sent out.

There has been no change to the Centers for Medicare & Medicaid Services (CMS) guidance clarifying Medicaid coverage of services for children with ASD pursuant to section 1905(a) of the Social Security Act for the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Under section 1905(r) of the Social Security Act, state Medicaid programs must cover medically necessary services for beneficiaries under 21 years of age, including those diagnosed with ASD. Therefore, Hawaii's QUEST Integration (QI) health plans must comply with the full range of EPSDT duties and requirements, including providing Intensive Behavioral Therapy (IBT) treatment modalities, which includes ABA, for children under 21 years of age with ASD, when based on individualized determinations of medical necessity. IBT is defined as a reliable,

evidence-based behavior intervention program designed to develop or restore the functioning of an individual diagnosed with ASD. IBT is not experimental and includes, but is not limited to, applied behavior analysis (ABA). IBT is not a long-term services and support (LTSS), home and community based service (HCBS), or respite service. In addition to IBT, speech therapy, physical therapy, and occupational therapy may also benefit individuals diagnosed with ASD and will not be replaced by IBT for beneficiaries under EPSDT. QI health plans shall ensure continuity of care for all beneficiaries already receiving services related to ASD.

Attachment A, revised December, 2016, identifies the MQD coverage guidelines on how to access ABA through QI health plans. Treatment provided and reimbursed by QI health plans shall include, but not be limited to ABA services when determined to be medically necessary. Attachment B provides a flow chart summarizing the process for accessing ABA through QI health plans. Attachment C identifies, for Medicaid fee-for-service (FFS) providers, the appropriate ABA procedure and diagnosis codes required for ICD-9 and ICD-10, as well as screening, diagnostics, assessment and treatment codes and reimbursement rates. Attachment D is a copy of the CMS FORM 1500 (02-12) Medicaid Billing Required Fields for the CMS 1500, and it is included to accompany the description of Claims Submittal Requirements, addressed in Attachment A.

This guidance does not apply to the Department of Education (DOE) school-based claiming or the Department of Health's Early Intervention Program (DOH-EIP). DOE may provide ABA or ABA-like services to a beneficiary while in school as it relates to a child's educational needs. If justification is provided indicating the ABA service is medically necessary and approved by the QI health plan, the health plan will be responsible to provide and cover ABA services before or after school and when school is not in session. The Early Intervention Program (EIP) may provide IBT services to its EIP beneficiaries aged 0 to three and will transition Medicaid recipients from EIP to QI health plans to cover ABA services. MQD will reimburse these state agencies for ABA services provided to Medicaid beneficiaries.

The ultimate responsibility to ensure that medically necessary ABA services are delivered to beneficiaries rests with the QI health plans. This responsibility is in effect all year, whether school is in session or out of session. QI health plans are expected to coordinate with the family, DOE and/or EIP to ensure that the beneficiary receives medically necessary ABA services in the most efficient manner that also takes into account the child's tolerance to benefit from receiving services in and outside of school.

Please direct any questions to the MQD provider hotline at 808-692-8099 or quest_integration@dhs.hawaii.gov.

Attachments

c: Department of Health, Developmental Disabilities Division (DOH-DDD)
Department of Health, Early Intervention Program (DOH-EIP)
Department of Education (DOE)

Guideline for Accessing Applied Behavior Analysis (ABA) Coverage for Autism Spectrum Disorder (ASD) through QUEST Integration (QI) Health Plans

Introduction

Diagnosing Autism Spectrum Disorder (ASD) can be complex and difficult due to the diversity and severity of symptoms presented. The fifth edition of the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM-5) includes a definition of ASD and combines several previously separate diagnoses of autistic disorders under the single diagnosis of ASD.

The multitude of possible causes and potential confusion with other conditions present a need for specialized diagnosis. There is no standard battery of tests to diagnose ASD, therefore practitioners are required to utilize the most suitable, evidenced-based testing available that evaluates each beneficiary's specific needs.

The available evidence of effectiveness suggests better outcomes with younger age at intake, higher initial developmental levels, and treatment intensity. It is vital that parents or guardians of a beneficiary suspected of having ASD seek early diagnosis for the beneficiary to increase potential benefits of treatment.

These guidelines are developed for Applied Behavior Analysis (ABA) services for beneficiaries with ASD. Though MQD covers other forms of Intensive Behavioral Therapy (IBT), the guidelines for accessing these services are not included in this attachment.

QUEST Integration (QI) beneficiaries under 21 years of age with a documented ASD diagnosis (that may include previous diagnoses such as autistic disorder, Asperger's disorder, childhood disintegrative disorder and pervasive developmental disorder) may be eligible to receive ABA through their QI health plan without undergoing an additional diagnostic evaluation. The QI health plan may request medical records with documentation of diagnosis and contact information of diagnosing provider from the beneficiary's Primary Care Provider (PCP).

This memorandum uses the titles diagnosing and rendering providers to provide clarity surrounding this complicated subject matter. These terms are only used for this memorandum and treatment of ASD.

The QI health plan is required to help the PCP, or any other healthcare professional caring for the beneficiary, find the correct diagnosing or rendering provider to move through steps of the process to prevent delay in care. This may include but not be limited to helping find a diagnosing or rendering provider for:

- Diagnosis of ASD;
- Psychological Testing; or
- Assessment and Treatment of ASD.

The process for receiving ABA includes:

1. Screening;
2. Diagnostic Evaluation;
3. Initial Assessment and Treatment Plan Development;
4. Applied Behavior Analysis (ABA); and
5. Re-evaluation

ABA is not a long-term services and support (LTSS), home and community based service (HCBS), or respite service.

Attachment B provides a flow chart that outlines the process for accessing ABA services.

1. Screening

Screening for potential ASD is a critical component and the first step in the treatment of ASD. It is the expectation of the State of Hawaii's Medicaid Program and the QI health plans that the beneficiary's PCP provides front line screening during Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) visits and any other PCP office visits. The PCP should assess the development of the beneficiary and discuss any concerns of developmental delays, communication, behavior, or interaction with parents/guardians. In addition, the PCP shall ensure that each comprehensive EPSDT examination includes surveillance for developmental delays, communication, and behavior problems. During other office visits, the PCP should perform developmental screening, if indicated. The PCP shall document, assess, and address concerns raised by parents/guardians at the time reported.

The PCP will perform an initial screening. If the screening indicates that the beneficiary needs further specialized evaluation, the PCP will either perform the diagnostic evaluation or refer to a diagnosing provider.

No prior authorization (PA) is required for screening; however, the PCP may contact the beneficiary's QI health plan for assistance in coordinating referral to a diagnosing provider. If the PCP diagnoses or if the beneficiary is already diagnosed with an ASD, the QI health plan will assist in coordinating referral to a qualified rendering provider for the initial assessment and treatment plan development (see Step #3 below), if indicated.

The PCP may request service coordination from the QI health plan. A service coordinator will support the beneficiary and his/her guardian/parent on navigating through the steps for accessing ABA. The PCP may request service coordination from the QI health plan by calling the QI health plan's provider relations telephone number (see below):

QI Health Plan	Contact Information- Accessing Service Coordination Provider Relations Telephone Number
AlohaCare	973-1650 or toll-free at 1-800-434-1002
HMSA	948-6486 or toll-free at 1-800-440-0640
Kaiser Permanente	(808) 282-3334
'Ohana Health Plan	1-888-846-4262
UnitedHealthcare Community Plan	1-888-980-8728

2. Diagnostic Evaluation

A diagnosis of ASD shall be made by one of the following licensed practitioners (diagnosing providers):

- Developmental behavioral pediatrician;
- Developmental pediatrician;
- Neurologist;
- Pediatrician;
- Psychiatrist;
- Psychologist; or
- Other licensed practitioner with specialized expertise in ASD.

Refer to Attachment C for codes that may be used for the diagnosing provider types listed above.

The diagnosing provider will perform a diagnostic evaluation of the beneficiary's behavior and development. Diverse presentations of ASD require that each evaluation be specific and address the variations from one beneficiary to another. Practitioners are required to utilize evidence-based assessments to evaluate the beneficiary's specific needs.

The diagnosing provider will refer beneficiaries diagnosed as meeting DSM-5 criteria for ASD to a rendering provider for assessment and treatment plan development. QI health plans shall help the diagnosing provider find a provider for initial assessment and treatment plan development, if requested.

Because of the complex nature of diagnosing, if the diagnosing provider suspects ASD and requires further evaluation before making a definitive diagnosis, the beneficiary may qualify for up to a 26-week trial of ABA. The QI health plan may approve extensions of the trial period or additional trial periods. Diagnosing providers may submit information to the QI health plan that includes diagnoses that qualify for a trial of ABA (i.e., social/pragmatic language disorder, mixed receptive expressive disorder, developmental delay, etc.) along with documentation of the beneficiary's developmental delays significantly affecting social communication and interaction along with restricted repetitive behaviors, interests, and activities.

If the beneficiary does not meet any of the current diagnostic criteria for ASD, the QI health plan shall help the diagnosing provider find another licensed practitioner who can provide other appropriate treatment.

Although prior authorization (PA) is not required for the diagnostic evaluation, QI health plans may require a referral from the PCP for this evaluation. In addition, if psychological testing is required, QI health plans may require PA.

3. Initial Assessment and Treatment Plan Development

The initial assessment and development of the treatment plan shall be performed by any of the following practitioners (rendering providers):

- Board Certified Behavioral Doctorate®™ (BCBA-D™);
- Board Certified Behavioral Analyst® (BCBA®); or
- Any of the diagnosing providers identified in Step #2 above.

Assessment and formulation of treatment goals will be consistent with the most current edition of the Behavior Analyst Certification Board (BACB) Applied Behavior Analysis Treatment of Autism Spectrum Disorders: Practice Guidelines for Healthcare Funders and Managers©[1]. The ABA assessment must consist of obtaining information from multiple informants and data sources, with direct observation in different settings and situations. The assessment will consist of gathering information from the following sources:

- File (record) Review;
- Interviews and Rating Scales;
- Direct Assessment and Observation; and
- Assessment from other Professionals

If requested by the rendering provider, the QI health plan shall help him/her find a licensed practitioner to perform components of the initial assessment. These components of the initial assessment may include intellectual and achievement tests, developmental assessments, assessments of comorbid mental health conditions, evaluations of family functioning and needs, standardized psychometric testing, assessment of general psychopathology, cognitive assessment, and assessment of adaptive behavior and communication. If additional testing is required, QI health plans may require PA. The QI health plan will directly reimburse any licensed practitioner who performs a component of the assessment.

The rendering provider will submit the assessment and treatment plan to the beneficiary's QI health plan for PA before treatment begins. The treatment plan will:

a. Address the identified behavioral, psychological, family, and medical concerns;

b. Have measurable goals in objective and measurable terms based on formalized assessments. The assessments shall address skills acquisition, the behaviors, and impairments for which the intervention is to be applied. (Note: For each goal, this should include baseline measurements, progress to date and anticipated timeline for achievement based on both the initial assessment and subsequent interim assessments over the duration of the intervention); and

c. Document that services will be delivered by a rendering provider who is licensed according to the requirements of the State of Hawaii's Medicaid Program. Hawaii Medicaid will accept

[1] "Copyright © 2014 by the Behavior Analyst Certification Board, Inc. ("BACB"), all rights reserved."

certification prior to licensure of behavior analysts when Centers for Medicare & Medicaid Services (CMS) has approved a State Plan Amendment that allows BCBA-D/BCBAs to function independently.

Refer to Attachment C for the appropriate procedure codes for the services listed above.

The rendering provider will obtain input into the development and updating of the treatment plan from the PCP, diagnosing provider, parent/guardian, and the beneficiary, as appropriate.

4. Applied Behavior Analysis (ABA)

The QI health plan will issue a PA for ABA when it determines ABA is medically necessary and recommended by a rendering provider. ABA services will be provided by or under the supervision of the rendering provider who assessed the beneficiary and formulated the treatment goals. Beneficiaries may receive ABA services in settings that maximize treatment outcomes, to include but not be limited to a clinic, in their home, or another community setting. The treatment plan shall include the goals and associated settings. Rendering providers are:

- Registered Behavior Technician™ (RBT™) (performing under the supervision of a BCBA, BCaBA, or BCBA-D as provided in Step #6 below);
- Board Certified Assistant Behavior Analyst® (BCaBA®) (performing under the supervision of a BCBA or BCBA-D as provided in Step #6 below);
- BCBA-D (as provided in Step #6 below);
- BCBA (as provided in Step #6 below); or
- Any of the diagnosing providers identified in Step #2 above working within the scope of their practice.

The individual-specific treatment plan includes age and impairment appropriate goals and measures of progress. The treatment plan shall include goals related to social skills, communication skills, language skills, behavior change and adaptive functioning that relate to the beneficiary. The health plan shall require documented measured progress as follows:

a. Interim progress assessment at least every 26 weeks based on clinical progress toward treatment plan goals; and

b. A generally accepted measurement of progress towards treatment plan goals. Examples of measurement systems may include VBMAPPS or ABLLS-R®.

Note: Treatment plans may be required by the QI health plan more often than every 26 weeks when warranted by individual circumstances.

In circumstances where the beneficiary is undergoing a trial period of ABA (as previously described in Step #2 above), the rendering provider will update and submit the individual-specific treatment plan at a minimum of 12 weeks (after the start of approved ABA) to the QI health plan.

Refer to Attachment C for codes QI health plans may use for the services listed above.

5. Re-evaluation

In order to avoid breaks in treatment, the rendering provider shall submit a request for prior authorization (PA) at least two weeks prior to the end of the approved treatment period. The PA request shall include a re-evaluation that assesses progress toward treatment goals. The QI health plan may continue to authorize ABA services for an individual with ASD when ALL of the following criteria are met:

a. For each goal in the individual-specific treatment plan, the following is documented:
   i. Re-evaluation is done no later than 24 weeks after the initial course of treatment has begun in order to establish a baseline in the areas of social skills, communication skills, language skills, behavior change and adaptive functioning;
   ii. Additional re-evaluations include measured progress and compare to baseline in the areas of social skills, communication skills, language skills, behavior change and adaptive functioning;
   iii. Progress to date; and
   iv. Anticipated timeline and treatment hours for achievement of the goal based on both the initial assessment and subsequent reevaluations over the duration of the intervention; and
b. Treatment plan criteria described in #4 above.

A qualified rendering provider may request a re-evaluation of the ASD diagnosis if there are significant concerns that the beneficiary's presentation of symptoms do not meet the diagnostic criteria for ASD.

6. QI Health Plan Administrative Requirements

a. Credentialing and Contracting of rendering providers
   i. QI health plans will follow their established [and Department of Human Services, Med-QUEST Division (MQD) reviewed and approved] credentialing and contracting processes for diagnosing and rendering providers involved in the screening, diagnosing, assessment, evaluation, treatment or any other aspect of services for ASD.
   ii. QI health plans shall ensure rendering providers are:
      (a) Appropriately licensed, if applicable, in the State of Hawaii;
      (b) Practicing within the scope of their licensure, if applicable;
      (c) If a BCBA-D, BCBA, BCaBA, or RBT, shall have obtained formal credentialing and certification within the profession of behavior analysts coordinated by the Behavior Analyst Certification Board (BACB);
      (d) If a licensed practitioner (i.e., psychologist), shall supervise the completion of functional assessments and treatment plans by BCBA-D and BCBAs until either:

(1) The State of Hawaii licenses BCBA-D/ BCBAs; or

(2) The MQD has a Centers for Medicare & Medicaid Services (CMS)-approved State Plan Amendment that allows BCBA-D/BCBAs to function independently; and

(e) If a BCaBA or RBT, shall work under the supervision of a BCBA-D, BCBA, or other licensed practitioner.

iii. Licensed practitioners may supervise up to ten (10) full-time (FT) unlicensed BCBA-D or BCBAs. Supervision includes review of and signing off on assessments and treatment plans.

iv. The supervision of BCaBA and RBTs includes:

(a) All aspects of clinical direction, supervision, and case management, including activities of the support staff and RBTs.

(b) Knowledge of each beneficiary and the treatment team's ability to effectively carry out clinical activities before assigning them.

(c) Familiarity with the beneficiary's assessment, needs, treatment plan, and regular observation of the rendering provider implementing the plan (at least two hours for every 10 hours of service provided with at least one of the two hours being direct clinical supervision).

b. Prior Authorization (PA) requirements

i. QI health plans shall request the same set of requirements to submit with all PA requests.

ii. No PA is required for EPSDT services provided by a PCP.

iii. No PA is required for a diagnostic evaluation (the QI health plan may require a referral from the PCP and psychological testing does require a PA).

iv. QI health plans shall determine and communicate their requirements and required forms for the assessment component of the process. PAs may be required for the whole assessment or health plans may allow a specific number of encounters prior to requiring authorization.

(a) PA is required for reimbursement for services provided under the treatment plan.

(b) QI health plans will prior authorize on-going services when the beneficiary is demonstrating documented improvement, ameliorating, or maintaining current developmental status in the following areas: social skills, communication skills, language skills, behavior change or adaptive functioning.

(c) Rendering providers may request a separate PA for treatment for school-aged beneficiaries when school is not in session.

(d) Rendering providers shall request prior authorization in hours/week for up to 26 weeks (i.e., six months).

(e) QI health plans will follow their established (MQD reviewed and approved) policy for prior authorization.

c. Reimbursement/Coding

i. Attachment C is a list of codes with reimbursement rates under the Hawaii Medicaid's fee-for-service program.

ii. QI health plans are not required but may use these established rates to reimburse for EPSDT covered services, including ABA,

iii. Payment for covered services by QI health plans shall only be made to a rendering provider:

(a) For services performed by a BCBA-D, BCBA, BCaBA or RBT, the QI health plan shall reimburse the licensed practitioner or the agency that contracts with or employs the licensed practitioner, the BCBA-D, BCBA, BCaBA or RBT.

(b) The code and modifier billed should reflect the face-to-face time exclusively spent with the beneficiary.

(c) A rendering provider may only bill for one beneficiary at a time except for provision of group services.

(d) If multiple rendering providers (i.e., licensed practitioner, BCBA-D, BCBA, BCaBA, and RBT) are providing services to a beneficiary at the same time, only one rendering provider may bill for the services.

(e) All codes for Assessment/Reassessment services and adaptive behavior treatment services require modifiers.

d. Non-Coverage/Non-Reimbursable

i. Treatment will only be covered when the criteria above are met; and

ii. Treatment will not be covered when any of the following apply:

(a) Care is primarily custodial in nature;

(b) Beneficiary is not medically stable;

(c) Services are provided by family or household members;

(d) Treatment is provided as LTSS, HCBS, or respite service;

(e) Treatments are considered experimental or lack scientifically proven benefit; or

(f) Services are provided by a Hawaii provider outside of the State.

e. Coordination of Benefits

i. Medicaid is secondary to all other insurance coverage; and

ii. Diagnosing and rendering providers and beneficiaries (or beneficiaries' families/guardians) should check with their QI health plan on coordination of benefits.

f. Coordination with Other State Programs

i. Early Intervention Program (EIP) is responsible to determine and provide for services provided to its EIP beneficiaries aged 0 to three. In addition, EIP and QI health plans will transition a beneficiary from EIP to QI health plan to cover ABA services through collaboration with an EI Care Coordinator and QI health plan service coordinator.

ii. Department of Education (DOE) will determine services to be provided to a beneficiary while the beneficiary is in school. Services provided by the DOE are for purposes of educational access and benefit only and will be determined in accordance with the IDEA. The QI health plan will collaborate with DOE, as applicable, to provide and reimburse for ABA services outside of school.

iii. QI health plans will provide medically necessary ABA services for beneficiaries in the 1915(c) Developmental and Intellectual Disabilities (DD/ID) waiver.

g. Claims Submittal Requirements

i. Claims for IBT services must be submitted on the CMS 1500 claim form. See Attachment D, CMS FORM 1500 (02-12) Medical Billing Required Fields for the CMS 1500.

ii. If submitted electronically, claims must be in CMS 1500 format.

iii. CMS 1500 identifies the requirements for each field [form locator (FL)].

iv. The following claim submittal requirements are specific to ABA services:

(a) **FL 24 D** - Use only the procedure codes and modifiers in Attachment C. All codes must have modifiers.

(b) **FL 24 J** - The rendering provider must be a qualified health care provider with a Hawaii license or the rendering BCBA or BCBA-D when CMS approves Hawaii Medicaid's State Plan Amendment.

(c) All rendering providers must have a National Provider Identifier (NPI) in order to submit a claim.

(d) State Tax is not covered.

v. Claims submitted with dates of service September 30, 2015, or prior need to include an ICD-9 code(s) on the CMS 1500 in FL#21.

vi. Claims submitted with dates of service October 1, 2015, or later need to include an ICD-10 code(s) on the CMS 1500 in FL#21.

vii. Information regarding appropriate ICD-9 and ICD-10 codes for ABA services may be found on Attachment C.

h. QI health plan communication of diagnosing and rendering providers

i. All QI health plans will identify their contracted providers for diagnosing ASD or rendering ABA services on their website.

ii. The QI health plan is required to help the PCP, or any other healthcare professional caring for the beneficiary, find the correct diagnosing or rendering provider to move through steps of the process to prevent delay in care. This may include but not be limited to helping find a diagnosing or rendering provider. Please contact the QI health plan as identified below for assistance.

i. Becoming a QI health plan provider for either diagnosing ASD or rendering ABA services

i. Providers who are interested in becoming either a diagnosing or a rendering provider may contact the QI health plans either by telephone or through their website. Each QI health plan has information on their website that describes steps to become a contracted provider.

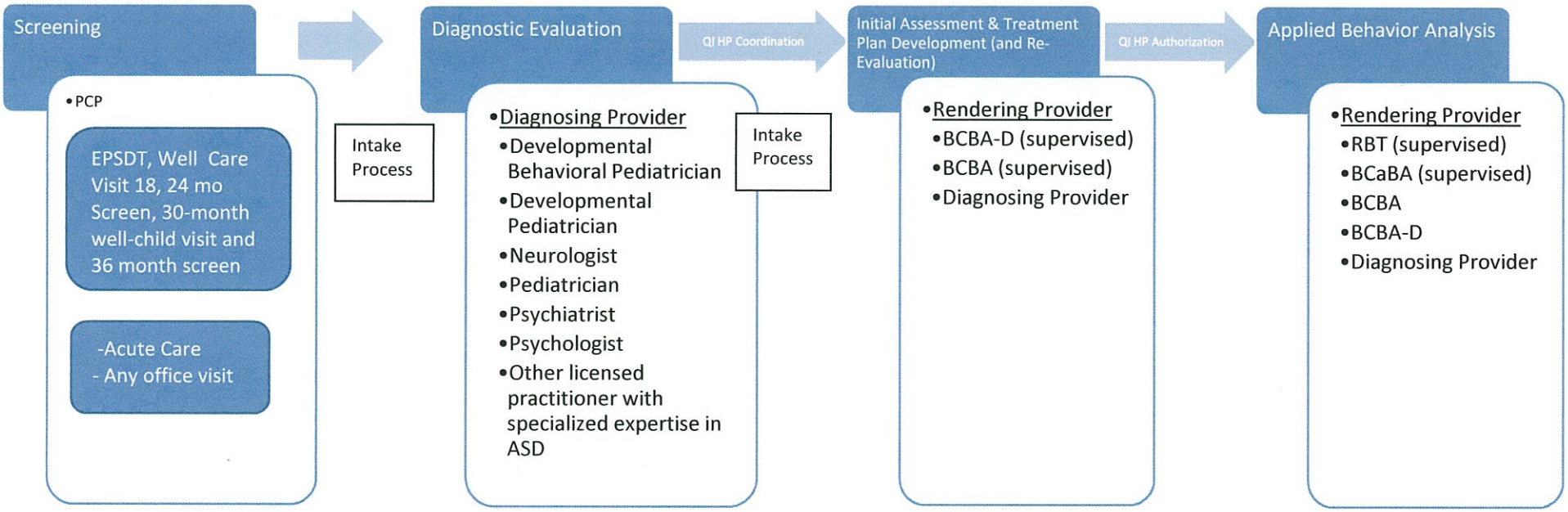
ii. Below is contact information for each QI health plan.

QI Health Plan	**Contact Information-Accessing Service Coordination**	**Contact Information** - Finding a diagnosing ASD or rendering ABA services provider - Becoming a QI health plan provider
AlohaCare	973-1650 or toll-free at 1-800-434-1002	973-1650 or toll-free at 1-800-434-1002 www.alohacare.org
HMSA	948-6486 or toll-free at 1-800-440-0640	948-6486 or toll-free at 1-800-440-0640 www.hmsa.com
Kaiser Permanente	(808) 282-3334	1-808-432-5777, ext. 1373 or www.kpquest.org
'Ohana Health Plan	1-888-846-4262	1-888-846-4262 or www.ohanahealthplan.com
UnitedHealthcare Community Plan	1-888-980-8728	1-888-980-8728 or www.uhccommunityplan.com

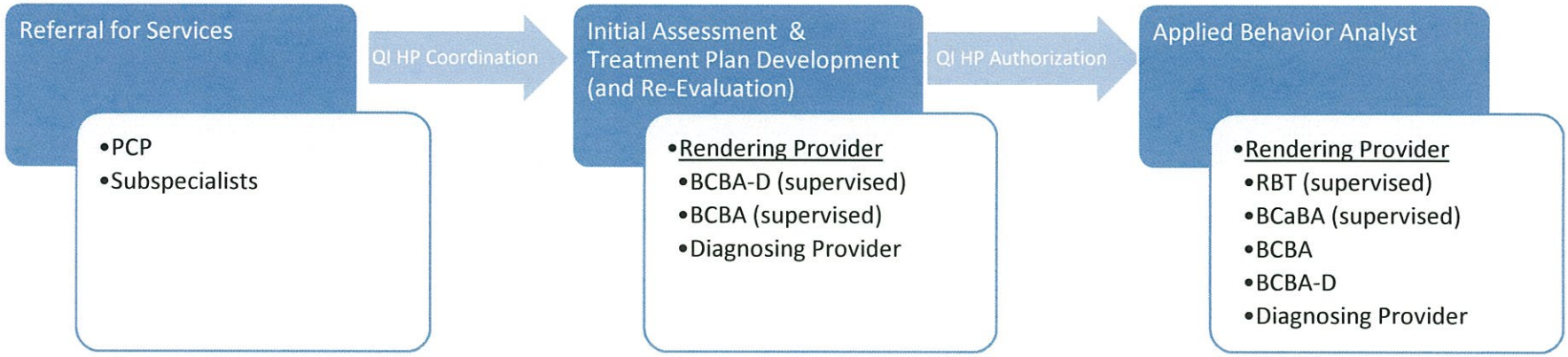
Attachment B

Process for Accessing Applied Behavior Analysis (ABA) from QUEST Integration (QI) health plans

New Diagnosis



Confirmed Diagnosis



Attachment C - FFS Coding/ Rates for Autism Spectrum Disorder (ASD) Screening, Procedures, Diagnostics and Treatment

Code	Mod	Service	Provider	Unit/Rate	Notes
Screening for ASD Phase					
Expectation is that ASD will be screened / identified through the EPSDT process, but ASD can be identified at any time during any visit with the member's PCP with subsequent referral made for diagnostic evaluation. Note: this is not an inclusive list for screening.					
99381-99385	EP	Initial new patient preventive medicine evaluation by age	Primary Care Provider	$120.00	<This section left blank>
99391-99395	EP	Established patient periodic preventive medicine exam by age	Primary Care Provider	$120.00	
99211	EP	Office visit, catch up	Primary Care Provider	$30.00	
99212	EP	Office visit, catch up	Primary Care Provider	$30.00	
99232	EP	Hospital visit	Primary Care Provider	$120.00	
99238	EP	Hospital discharge day mgmt.; Modifier not covered	Primary Care Provider	$50.28 no modifier	
99460-99461	EP	Initial hospital/birthing center care; initial newborn eval. per day	Primary Care Provider	$120.00	
99348	EP	Established patient home visit	Primary Care Provider	$120.00	
96110	EP	Developmental testing; limited (i.e., Developmental Screening Test II, Early Language, Milestone Screen), with interpretation and report	Primary Care Provider	$39.85	
Diagnostic Evaluation for ASD					
96111		Developmental testing	MD/DO	$79.69	Typical provider performing the service would be a developmental behavioral pediatrician, developmental pediatrician, neurologist, pediatrician, psychiatrist, psychologist, (at the discretion of the QI health plan), other licensed practitioner with specialized expertise in ASD. When performed by other licensed practitioner, use modifier TD for APRN or AJ for licensed clinical social worker
			Psychiatrist/ Psychologist	$79.69	
96101		Psychological testing per hour; max 10 requires PA	MD/DO Psychologist	$59.90/hour	
90791	none	Psychiatric diagnostic exam	Psychiatrist/ Psychologist	$104.43	

Attachment C - FFS Coding/ Rates for Autism Spectrum Disorder (ASD) Screening, Procedures, Diagnostics and Treatment

Code	Mod	Service	Provider	Unit/Rate	Notes
90792	none	Psychiatric diagnostic evaluation with medical services (includes medical assessment—history, physical exam, recommendations)	Psychiatrist Physician	$104.43	(payment will be 75% of the rates of the psychologist/physician rate) Diagnostic evaluation cannot be performed by a BCBA/D, BCaBA, or RBT (technician). Either 90791 or 90792 (not both) will be reimbursed a maximum of once per day. Both codes cannot be billed on the same day as an evaluation and management (E & M) service
Assessment/Reassessment Phase[1]					
0359T	HP	Behavior identification assessment, by the physician or other qualified health care provider, 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	BCBA-D (or otherwise qualified licensed practitioners as determined by DHS)	1 unit = 1 session MQD FFS rate = $187.50	Reassessment may be reported with the assessment code 0359T. A reassessment is typically required after the success or failure of the current treatment plan necessitating new and/or revised treatment goal(s). A behavior identification assessment (0359T) may be followed by an observational assessment of behavioral functioning (0360T, 0361T) or exposure behavioral follow-up assessment(s) (0362T, 0363T). Code 0359T may be reported for the assessment required for early intensive behavioral intervention (EIBI). A typical session is approximately 90 minutes of face-to-face time with patient and parent/guardian. BCBA or BCBA-D provider that will typically do assessment/reassessment. Cannot be performed by a BCaBA or RBT (technician).
	HO		BCBA (or otherwise qualified licensed practitioners as determined by DHS)		
0360T	HP	Observational behavioral follow-up assessment, includes physician or other qualified health care provider direction with interpretation and	BCBA-D (or otherwise qualified licensed practitioners	First 30 min. Maximum of 1 unit per day; 1 unit= 30 min MQD FFS rate = $62.50	When more than one provider is present in the same session with the patient, codes 0360T, 0361T, 0362T, and 0363T are based on a single provider's face-to-face time with the patient and

[1] The codes identified for Assessment/Reassessment phase are from the CPT Assistant from the American Medical Association (June 2014/Vol 24 Issue 6).

Attachment C - FFS Coding/ Rates for Autism Spectrum Disorder (ASD) Screening, Procedures, Diagnostics and Treatment

Code	Mod	Service	Provider	Unit/Rate	Notes
		report. May be administered by one BCBA-D, BCBA, or BCaBA; first 30 minutes of BCBA-D, BCBA, or BCaBA time, face-to-face with the patient	as determined by DHS)		not the combined time of multiple providers. Thus, if more than one BCBA-D, BCBA, or BCaBA, only one 30 min session is billable. 0360T and 0362T are codes for the first 30 min of service and can be billed a maximum of once per day regardless of who provided the service.
	HO		BCBA (or otherwise qualified licensed practitioners as determined by DHS)	First 30 min. Maximum of 1 unit per day; 1 unit= 30 min MQD FFS rate = $62.50	
	HN		BCaBA	First 30 min. Maximum of 1 unit per day; 1 unit= 30 min MQD FFS rate = $37.50	
0361T	HP	Each additional 30 minutes of BCBA-D, BCBA, or BCaBA time, face-to-face with the patient (List separately in addition to code for primary service) (Use 0361T in conjunction with 0360T)	BCBA-D (or otherwise qualified licensed practitioners as determined by DHS)	1 unit= 30 min MQD FFS rate = $62.50	
	HO		BCBA (or otherwise qualified licensed practitioners as determined by DHS)	1 unit= 30 min MQD FFS rate = $62.50	
	HN		BCaBA	1 unit = 30 min MQD FFS rate = $37.50	
0362T	HP	Exposure behavioral follow-up assessment, includes physician or other qualified health care provider direction with interpretation and report, administered by physician or other qualified health care provider with the assistance of one or more technicians; first 30 minutes of technician(s) time, face-to-face with the patient	BCBA-D (or otherwise qualified licensed practitioners as determined by DHS)	First 30 min. Maximum of 1 unit per day; 1 unit= 30 min MQD FFS rate = $62.50	0362T, 0363T are reported based on a single provider's face-to-face time with the patient and not the combined time of multiple providers. In reporting codes 0362T and 0363T, only the face-to-face time spent by any one provider during a single session of sequential time may be counted. Because the service requires the presence of the BCBA/BCBA-D, these services must be coded with either the modifier HP or HO. If the physician or other qualified health care provider personally performs the BCBA/BCBA-D
	HO		BCBA (or otherwise qualified licensed practitioners as determined by DHS)		

Attachment C - FFS Coding/ Rates for Autism Spectrum Disorder (ASD) Screening, Procedures, Diagnostics and Treatment

Code	Mod	Service	Provider	Unit/Rate	Notes
	HN		BCaBA	First 30 min. Maximum of 1 unit per day; 1 unit= 30 min MQD FFS rate = $37.50	service, his or her time engaged in these activities are payable at the BCBA, BCBA-D rate and must be coded with the modifier AF (specialty physician), AH (psychologist); AJ (licensed clinical social worker), TD (APRN).
0363T	HP	Each additional 30 minutes of technician(s) time, face-to-face with the patient (List separately in addition to code for primary procedure) (Use 0363T in conjunction with 0362T)	BCBA-D (or otherwise qualified licensed practitioners as determined by DHS)	Additional 30 min. 1 unit = 30 min MQD MQD FFS rate=$62.50	
	HO		BCBA (or otherwise qualified licensed practitioners as determined by DHS)		
	HN		BCaBa	Additional 30 min. 1 unit = 30 min MQD MQD FFS rate=$37.50	
Adaptive Behavior Treatment[2]					
0364T	HP HO	Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; first 30 minutes of BCBA-D, BCBA time	BCBA-D or BCBA (or otherwise qualified licensed practitioners as determined by DHS)	First 30 min. Maximum of 1 unit per day; 1 unit= 30 min MQD FFS rate = $62.50	BCBA-D or BCBAs may only provide three (3) sessions per week except under extenuating circumstances.
0364T	HN HM	Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; first 30 minutes of technician time	BCaBAs RBT (technician)	First 30 min. Maximum of 1 unit per day; 1 unit= 30 min FFS rate = $25.00	<This section left blank>

[2] The codes identified for Adaptive Behavior Treatment are from the CPT Assistant from the American Medical Association (June 2014, Vol 24, Issue 6).

Attachment C - FFS Coding/ Rates for Autism Spectrum Disorder (ASD) Screening, Procedures, Diagnostics and Treatment

Code	Mod	Service	Provider	Unit/Rate	Notes
0365T	HP HO	Each additional 30 minutes of BCBA-D or BCBA time (List separately in addition to code for primary procedure) (Use 0365T in conjunction with 0364T)	BCBA-D or BCBA (or otherwise qualified licensed practitioners as determined by DHS)	Additional 30 min. 1 unit = 30 min MQD MQD FFS rate=$62.50	BCBA-D or BCBAs may only provide three (3) sessions per week except under extenuating circumstances.
0365T	HN HM	Each additional 30 minutes of technician time (List separately in addition to code for primary procedure) (Use 0365T in conjunction with 0364T)	BCaBAs RBT (technician)	Additional 30 min. 1 unit = 30 min MQD FFS rate = $25.00	<This section left blank>
0366T	UN UP UQ UR US	Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time, modifier designates group size	BCBA BCBA-D BCaBAs RBT (technician)	First 30 min. Maximum of 1 unit per day 1 unit = 30 min MQD FFS rate by group size 2 patients: $25/pt. 3 patients: $23/pt. 4 patients: $21/pt. 5 patients: $19/pt. 6 to 8 patients: $17/pt.	Do not report codes 0366T and 0367T for patients in groups larger than 8 patients (limit group to no more than 8). Report group adaptive behavior treatment by protocol (0366T, 0367T) only for patients who are participating in the interaction in order to meet their own individual treatment goals. Modifier identifies group size: UN (2), UP (3), UQ (4), UR (5), and US (6 to 8 patients). Billing based on actual group size present when services rendered. Only one 0366T payable per day.
0367T	UN UP UQ UR US	Each additional 30 minutes of technician time (List separately in addition to code for primary procedure) (Use 0367T in conjunction with 0366T), modifier designates group size	BCBA BCBA-D BCaBAs RBT (technician)		
0368T	HP	Adaptive behavior treatment with protocol modification administered by physician or	BCBA-D (or otherwise qualified licensed practitioners as determined by DHS)	First 30 min. Maximum of 1 unit per day 1 unit = 30 min MQD FFS rate = $62.50	When the physician or other qualified health care provider instructs the provider about the treatment protocol without the patient present, the service is not reported separately.

Attachment C - FFS Coding/ Rates for Autism Spectrum Disorder (ASD) Screening, Procedures, Diagnostics and Treatment

Code	Mod	Service	Provider	Unit/Rate	Notes
	HO	other qualified health care provider with one patient; first 30 minutes of patient face- to-face time	BCBA (or otherwise qualified licensed practitioners as determined by DHS)		If the physician or other qualified health care provider personally performs the BCBA/BCBA-D service, his or her time engaged in these activities are payable at the BCBA, BCBA-D rate and must be coded with the modifier AF (specialty physician), AH (psychologist); AJ (licensed clinical social worker), TD (APRN).
	HN		BCaBA	1 unit = 30 min MQD FFS rate = $37.50	BCaBA may perform this service under the supervision of a BCBA-D or BCBA.
0369T	HP	Each additional 30 minutes of patient face-to-face time (List separately in addition to code for primary procedure) (Use 0369T in conjunction with 0368T)	BCBA-D (or otherwise qualified d licensed practitioners as determined by DHS)	Additional 30 min 1 unit = 30 min MQD FFS rate = $62.50	When the physician or other qualified health care provider instructs the provider about the treatment protocol without the patient present, the service is not reported separately. If the physician or other qualified health care provider personally performs the BCBA/BCBA-D service, his or her time engaged in these activities are payable at the BCBA, BCBA-D rate and must be coded with the modifier AF (specialty physician), AH (psychologist); AJ (licensed clinical social worker), TD (APRN).
	HO		BCBA (or otherwise qualified licensed practitioners as determined by DHS)		
	HN		BCaBA	Additional 30 min 1 unit = 30 min MQD FFS rate = $37.50	BCaBA may perform this service under the supervision of a BCBA-D or BCBA.
0370T	HP	Family adaptive behavior treatment guidance, administered by physician or other qualified health care provider (without the patient present)	BCBA or BCBA-D (or otherwise qualified licensed practitioners as determined by DHS)	Untimed, FFS rate = $125.00	Note: 0370T is for family adaptive behavior treatment for (1) patient's family, for multiple patients (group) use 0371T. Expected minimum session time of 45 minutes. If the physician or other qualified health care provider personally performs the BCBA/BCBA-D service, his or her time engaged in these activities are payable at the BCBA, BCBA-D rate and must be coded with the modifier AF (specialty physician), AH (psychologist); AJ (licensed clinical social worker), TD (APRN).
	HO				

Attachment C - FFS Coding/ Rates for Autism Spectrum Disorder (ASD) Screening, Procedures, Diagnostics and Treatment

Code	Mod	Service	Provider	Unit/Rate	Notes
					Only one 0370T billable per day
	HN		BCaBA	Untimed, FFS rate = $75.00	BCaBA may perform this service under the supervision of a BCBA-D or BCBA.
0371T	UN UP UQ UR US	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care provider (without the patient present)	BCBA or BCBA-D (or otherwise qualified licensed practitioners as determined by DHS) BCaBA	Untimed, FFS rate by group size 2 families: $93.75/family 3 families: $88.75/family 4 families: $83.75/family 5 families: $78.75/family 6 families: $73.75/family	Do not report codes 0370T and 0371T if the group includes guardian(s)/ caregiver(s) of more than 6 patients (limit group size to 6 families) Modifier identifies group size: UN (2 or less), UP (3), UQ (4), UR (5), and US (6) (where group size = # families) Billing based on actual group size (# of families) present when services rendered. Expected minimum session time of 45 minutes. Only one 0371T billable per day
0372T	UN UP UQ UR US	Adaptive behavior treatment social skills group, administered by physician or other qualified health care provider face-to-face with multiple patients	BCBA or BCBA-D (or otherwise qualified licensed practitioners as determined by DHS) BCaBA	Untimed, FFS rate by group size 2 patients: $93.75/pt. 3 patients: $88.75/pt. 4 patients: $83.75/pt. 5 patients: $78.75/pt. 6 to 8 patients: $73.75/pt.	Do not report the code 0372T if the group size is larger than 8 patients (limit group size to 8). Report adaptive behavior treatment social skills group (0372T) only for patients who are participating in the interaction in order to meet their own individual treatment goals. Modifier identifies group size: UN (2 or less), UP (3), UQ (4), UR (5), and US (6 to 8 patients) Billing based on actual group size present when services rendered. Expected minimum session time of 45 minutes.

Attachment C - FFS Coding/ Rates for Autism Spectrum Disorder (ASD) Screening, Procedures, Diagnostics and Treatment

Code	Mod	Service	Provider	Unit/Rate	Notes
					If the physician or other qualified health care provider personally performs the BCBA/BCBA-D service, his or her time engaged in these activities are payable at the BCBA, BCBA-D rate and must be coded with the modifier AF (specialty physician), AH (psychologist); AJ (licensed clinical social worker), TD (APRN).
0373T	HP	Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians' time, face-to-face with patient	BCBA-D (or otherwise qualified licensed practitioners as determined by DHS)	1 unit = 60 min MQD FFS rate = $125.00	(0373T, 0374T are reported based on a single technician's face-to-face time with the patient and not the combined time of multiple technicians). Exposure adaptive behavior treatment is typically provided in a structured, safe environment (e.g., padded room), and protective gear is utilized as needed to protect the patient and the technicians and other qualified health care providers. In reporting codes 0373T, 0374T, only the face-to-face time spent by one technician during a single session of sequential time may be counted. Although the physician or other qualified health care provider is on-site, he or she may be directing 5-10 other similar treatments simultaneously. Treating provider will determine modifier & reimbursement level. Only one 0373T billable per day regardless of the modifier used.
	HO		BCBA (or otherwise qualified licensed practitioners as determined by DHS)		
	HN		BCaBA	1 unit = 60 min MQD FFS rate = $75.00	
	HM		RBT (technician)	1 unit = 60 min MQD FFS rate = $50.00	
0374T	HP	Each additional 30 minutes of technicians' time face-to-face with patient (List separately in addition to code for primary procedure)	BCBA-D (or otherwise qualified licensed practitioners as determined by DHS)	1 unit = 30 min MQD FFS rate = $62.50	

Attachment C - FFS Coding/ Rates for Autism Spectrum Disorder (ASD) Screening, Procedures, Diagnostics and Treatment

Code	Mod	Service	Provider	Unit/Rate	Notes
	HO	(Use 0374T in conjunction with 0373T)	BCBA (or otherwise qualified licensed practitioners as determined by DHS)		
	HN		BCaBA	1 unit = 30 min MQD FFS rate = $37.50	
	HM		RBT (technician)	1 unit = 30 min MQD FFS rate = $25.00	

Attachment C - FFS Coding/ Rates for Autism Spectrum Disorder (ASD) Screening, Procedures, Diagnostics and Treatment

Modifiers

Modifier	Description
EP	Services provided as part of Medicaid early periodic screening diagnosis and treatment (EPSDT) program
HP	Doctoral level
HO	Master's degree level
HN	Bachelor's degree level
HM	Less than bachelor degree level
UN	Two patients or families served
UP	Three patients or families served
UQ	Four patients or families served
UR	Five patients or families served
US	Six to eight patients or families served
Modifiers for use when the Diagnostic Evaluation is performed by non-physicians, non-psychiatrist but by other licensed practitioners with specialized expertise in ASD	
TD	Advanced Practice Registered Nurse (APRN)
AJ	Licensed Clinical Social Worker
Modifiers for use when physician or other qualified health professional performs Assessment/Reassessment and Adaptive Behavior Treatment	
AF	Specialty Physician
AH	Clinical Psychologist
TD	Advanced Practice Registered Nurse (APRN)
AJ	Licensed Clinical Social Worker

Diagnosis Codes

Description	DSM-IV	DSM-V	ICD-9	ICD-10
Autism Spectrum Disorder		299.00		
Atypical Autism	299.80			F84.1
Autistic Disorder	299.00		299.0	F84.0
Asperger's Disorder	299.80	299.00	299.8	F84.5
Childhood Autism				F84.0
Pervasive Developmental Disorder, NOS	299.80	299.00	299.8	F84.9
Other pervasive developmental disorders	299.80			F84.8
Overactive disorder associated with mental retardation and stereotyped movements	299.80			F84.4
Childhood Disintegrative Disorder, NOS	299.10		299.9	F84.3
Rett's Disorder	299.80		330.8	F84.2 Genetic disorder

Notes:

- Must use ICD10 on/after October 1, 2015 (no DSM IV or V)
- Providers must use DSM-V to diagnosis autism effective October 1, 2015. Prior to October 1, 2015, MQD will accept a diagnosis using DSM-IV.
- Providers must bill with valid diagnosis code (table above) to be reimbursed for ASD treatment procedures
- Providers do not need to bill with autism related diagnosis code for EPSDT/similar screening visit or for diagnosing providers

IBT providers (partial list):

Board Certified Behavioral Analyst/Doctorate® (BCBA / BCBA-D™):

The BCBA and BCBA-D are independent practitioners who also may work as employees or independent contractors for an organization. The BCBA conducts descriptive and systematic behavioral assessments, including functional analyses, and provides behavior analytic interpretations of the results. The BCBA designs and supervises behavior analytic interventions. The BCBA is able to effectively develop and implement appropriate assessment and intervention methods for use in unfamiliar situations and for a range of cases. The BCBA seeks the consultation of more experienced practitioners when necessary. The BCBA teaches others to carry out ethical and effective behavior analytic interventions based on published research and designs and delivers instruction in behavior analysis. BCBAs supervise the work of Board Certified Assistant Behavior Analysts and others who implement behavior analytic interventions.

Board Certified Assistant Behavior Analyst® (BCaBA®):

The BCaBA conducts descriptive behavioral assessments and is able to interpret the results and design ethical and effective behavior analytic interventions for clients. The BCaBA designs and oversees interventions in familiar cases (e.g., similar to those encountered during their training) that are consistent with the dimensions of applied behavior analysis. The BCaBA obtains technical direction from a BCBA for unfamiliar situations. The BCaBA is able to teach others to carry out interventions and supervise behavioral technicians once the BCaBA has demonstrated competency with the procedures involved under the direct supervision of a BCBA. The BCaBA may assist a BCBA with the design and delivery of introductory level instruction in behavior analysis. It is mandatory that each BCaBA practice under the supervision of a BCBA. Governmental entities, third-party insurance plans and others utilizing BCaBAs must require this supervision.

Registered Behavior Technician™ (RBT™):

The RBT is a paraprofessional who practices under the close, ongoing supervision of a BCBA or BCaBA ("designated RBT supervisor"). The RBT is primarily responsible for the direct implementation of skill-acquisition and behavior-reduction plans developed by the supervisor. The RBT may also collect data and conduct certain types of assessments (e.g., stimulus preference assessments). The RBT does not design intervention or assessment plans. It is the responsibility of the designated RBT supervisor to determine which tasks an RBT may perform as a function of his or her training, experience, and competence. The designated RBT supervisor is ultimately responsible for the work performed by the RBT.

Note: Individuals who hold the BCBA credential should be considered as having met and exceeded standards for the BCaBA and RBT credentials. Individuals who hold the BCaBA credential should be considered as having met and exceeded standards for the RBT credential. However, individuals holding a BACB credential should represent themselves using only the highest credential awarded to them by the BACB.

Attachment D

Medicaid Billing Required Fields for the CMS 1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED ____ DATE	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. b.	33. BILLING PROVIDER INFO & PH # ( ) a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE* APPROVED OMB-0938-1197 FORM 1500 (02-12)

Attachment D

Medicaid Billing Required Fields for the CMS 1500

FL #	Field Name	Requirement	Information Required
1	Insurance Coverage	Required	Indicate the type of insurance coverage applicable to this claim by placing an "X" in the appropriate box. Only one box can be marked.
1a	Insured's ID Number	Required	Insured's ID number as shown on the Medicaid ID card (HAWI ID #).
2	Patient's Name	Required	Patient's full name as it appears on the Medicaid ID card.
3	Patient's Birth Date, Sex	Required	Patient's birth date (MM/DD/YYYY). Enter an "X" in the appropriate box to indicate the sex of the patient.
5	Patient's Address	Required	Patient's street, city, state, zip code, area code and phone #.
6	Patient Relationship to Insured	Required	Enter an "X" in the correct box to indicate the patient's relationship to insured.
9	Other Insured's Name	Conditional	If FL11d is marked, complete fields 9, 9a, and 9d. Otherwise leave blank. When additional health coverage exists, enter the other insured's full name if it is different from that shown if FL2.
9a	Other Insured's Policy or Group	Conditional	Policy or group number of the other insured.
9d	Insurance Plan Name or Program	Conditional	Other insured's plan or program name.
10a-c	Is Patient's Condition Related to:	Required	Indicate whether the patient's condition is a result of an employment, auto, or other type of accident.
11	Insured's Policy, Group, or FECA Number	Conditional	If the patient has another TPL, indicate the TPL policy number. If FL4 is complete, this field should be completed.
11c	Insurance Plan Name or Program	Conditional	Insurance plan or program name of the insured.
11d	Is there another Health Benefit Plan?	Conditional	Enter an "X" in the correct box. If marked YES, complete 9, 9a and 9d.
12	Patient's or Authorized Person's Signature	Required	Patient's or authorized person's signature releases any medical or other information necessary to process a claim. If the signature is on file, indicate "Signature on file" and date.
14	Date of Current Illness, Injury, Pregnancy	Conditional	Enter the first date of the present illness, injury, or pregnancy (MM/DD/YY).
17	Name of Referring Provider or Other Source	Conditional	Name and credentials of the referring physician are only required for consults (99241—99275). Leave blank if not a referral.
17a	Other ID #	Conditional	Medicaid qualifier "1D" and the legacy number is required when referring physician is an atypical provider.

Attachment D

Medicaid Billing Required Fields for the CMS 1500

FL #	Field Name	Requirement	Information Required
17b	NPI#	Conditional	Enter the NPI of the referring provider.
18	Hospitalization Dates Related to Current Services	Conditional	Required for hospitalizations only. Enter the admit date followed by the discharge date. If not discharged, leave discharge date blank (MM/DD/YY).
19	Reserved for Local Use	Conditional	If it is known that the TPL does not cover a certain service, a denial does not have to be obtained, but you must indicate "Not a (name of TPL) covered service".
21	Diagnosis or Nature of Illness or Injury	Required	List up to 12 diagnosis codes. For dates of service on or after 10/1/2015 only ICD-10 codes will be accepted. Use the highest level of specificity possible. Do not add provider narrative in this field. Relate the appropriate diagnosis code to the lines of service in FL24E using the appropriate alpha pointer.
22	Medicaid Resubmission	Conditional	Required for resubmissions only. Enter "A" (to adjust) or "V" (to void). Also enter the original 12-digit claim reference number.
23	Prior Authorization Number	Conditional	Waiver providers must indicate a "W".
24A	Date(s) of Service [lines 1-6]	Required	Date(s) of service, from and to.
24B	Place of Service [lines 1-6]	Required	Enter the 2-digit place of service. **
24C	EMG [lines 1-6]	Conditional	Required for emergency services. Enter "Y" for YES or leave blank if no. **
24D	Procedures, Services, or Supplies [lines 1-6]	Required	Enter the CPT or HCPCS code(s) and modifier(s) (if applicable) from the appropriate code set on the date of service. **
24E	Diagnosis Pointer [lines 1-6]	Required	Enter the diagnosis reference letter (pointer) as shown in FL21 to relate the date of service and the procedures performed to the primary diagnosis. **
24F	$ Charges [lines 1-6]	Required	Do not add commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number. Symbols that denote no charge for service, such as "N/C" and slashes or dashes are not a valid charges of service.

Attachment D

Medicaid Billing Required Fields for the CMS 1500

FL #	Field Name	Requirement	Information Required
24G	Days or Units [lines 1-6]	Required	Enter the number of service units, visits or days applicable to each line. If field is left blank, the number is assumed to be 1. **
24H	EPSDT/Family Plan [lines 1-6]	Conditional	For Early & Periodic Screening, Diagnosis, and Treatment relates services. Enter a "E" only when requesting follow-ups for catch-up and preventative services. **
24I	ID Qualifier [lines 1-6]	Conditional	Enter qualifier "1D" if the provider number is the 6 or 8 digit Medicaid provider ID.
24J	Rendering Provider ID # [lines 1-6]	Required	Effective August 1, 2007 the NPI must be indicated in the un-shaded region. If an atypical provider, enter the legacy number in the shaded area.
25	Federal Tax ID Number	Required	Enter the provider of service or supplier's Federal Tax ID (employer identification number) or Social Security Number. Enter an "X" in the appropriate box to indicate which number is being reported.
26	Patient Account No.	Conditional	Enter the provider patient reference or account number.
27	Accept Assignment	Required	Enter an "X" in the correct box. Only one can be marked. Medicaid requires YES to be checked.
28	Total Charge	Required	Sum of total line charges. (i.e., total of all charges in FL24F).
29	Amount Paid	Conditional	Enter total third party amount paid.
31	Signature of Physician or Supplier	Required	Signature of Physician or Supplier Including Degrees or Credentials.
32	Service Facility Location Information	Conditional	If the service was rendered in a Facility or Hospital, or if different from billing address, enter the name and address of the facility.
32a	NPI #	Conditional	Effective August 1, 2007, enter the NPI of the service facility.
32b	Other ID #	Conditional	Enter the Medicaid qualifier "1D" followed by the Legacy number (for atypical providers).
33	Billing Provider Info & Ph #	Required	Enter the provider's or supplier's billing name, address, and phone number.
33a	NPI #	Conditional	Effective August 1, 2007, enter the NPI of the billing provider.
33b	Other ID #	Conditional	Enter the Medicaid qualifier "1D" followed by the Legacy number (for atypical providers).
NOTE			** denotes that the information must be indicated in the un-shaded section of the field.