

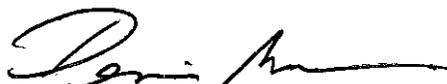


| | | |
|--------------------------------------|---|---------------------------|
| ISSUE DATE August 17, 2016 | EFFECTIVE DATE September 30, 2016 | NUMBER 99-16-15 |
|--------------------------------------|---|---------------------------|

SUBJECT
Payment of Claims for Services Provided to
Children and Adolescents for the Diagnostic Assessment and Treatment of Autism Spectrum
Disorder

BY

Leesa M. Allen, Deputy Secretary
Office of Medical Assistance Programs

BY

Dennis Marion, Deputy Secretary
Office of Mental Health and
Substance Abuse Services

IMPORTANT REMINDER: All providers must revalidate their MA enrollment every 5 years. Providers should log into PROMISE to check their revalidation date and submit a revalidation application at least 60 days prior. Enrollment (revalidation) applications may be found at http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994. Providers who enrolled on or before SEPTEMBER 25, 2011 must complete the revalidation process as soon as possible. DHS must complete the revalidation for all providers enrolled on or before September 25, 2011 by September 25, 2016.

PURPOSE:

The purpose of this bulletin is to remind providers enrolled in the Medical Assistance (MA) Program of the requirement to bill a child’s or adolescent’s private health insurance company before submitting a claim for the diagnostic assessment or treatment of Autism Spectrum Disorder (ASD) and to inform providers of the diagnosis codes and procedure codes which will be included in the MA Fee-For-Service (FFS) cost avoidance process, effective September 30, 2016.

SCOPE:

This bulletin applies to all MA enrolled providers who diagnose or provide treatment of ASD to children and adolescents in the MA FFS and MA managed care delivery systems. Providers rendering services in the MA managed care delivery system should address any claims processing and cost avoidance questions to the appropriate physical health and behavioral health MA managed care organization (MCO).

BACKGROUND/DISCUSSION:

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll free number for your provider type

Visit the Office of Medical Assistance Programs Web site at
<http://www.dhs.pa.gov/provider/healthcaremedicalassistance/index.htm>

Act 62 of 2008 (Act 62) requires the MA Program, the Children's Health Insurance Program (CHIP), and certain private health insurance policies to cover some of the costs of the diagnostic assessment and treatment of ASD for children and adolescents under 21 years of age. The Act 62 coverage mandate applies to employer group health insurance policies (including Health Maintenance Organization and Preferred Provider Organization plans) issued in Pennsylvania to groups of 51 or more employees. Act 62 does not apply to policies that are issued outside of Pennsylvania, that are "self-funded", or are subject to the Employee Retirement Income Security Act of 1974.

Act 62 defines diagnostic assessment of ASD as assessments, evaluations, or tests performed by licensed physicians, licensed physician assistants, licensed psychologists, or certified registered nurse practitioners to diagnose whether an individual has ASD. Treatment of ASD includes pharmacy care; psychiatric care; psychological care; rehabilitative care, which includes applied behavioral analysis (ABA); and therapeutic care, including services provided by speech language pathologists, occupational therapists, and physical therapists.

The maximum amount private health insurance companies are required to pay as a result of Act 62 for the diagnostic assessment and treatment of ASD (known as the "cap") is adjusted annually (\$38,562.00 in 2016). The coverage that must be provided is subject to copayment, deductible, coinsurance, and any other general exclusions or limitations of the health insurance policy to the same extent as other medical services covered by the policy are subject to these provisions.

Federal law requires Medicaid be payer of last resort (42 CFR 433.139). The Department utilizes data-matching processes to determine whether the child or adolescent has private health insurance coverage. This private health insurance coverage information is utilized during the processing of FFS claims to ensure the provider has billed the private health insurance company first and to check if the claim has either been paid or denied. This process is referred to as "cost avoidance". MA managed care organizations also utilize cost avoidance in claims processing.

Beginning September 30, 2016, the Department will expand the list of diagnoses and procedure codes subject to the MA FFS cost avoidance process to ensure that the MA program is the payer of last resort of claims for services that are for the diagnostic assessment or treatment of ASD for children and adolescents under 21 years of age.

PROCEDURE:

The Department's clinical staff identified procedure codes that reflect services for the diagnostic assessment and treatment of ASD covered under Act 62. The procedure codes that are on the MA Program fee schedule will be subject to the cost avoidance process for MA FFS claims beginning September 30, 2016. The procedures codes are on the Department's website at:

<http://www.dhs.pa.gov/citizens/paautisminsuranceact62/index.htm>.

The Department will continue to review procedure codes to identify additional codes that reflect services subject to Act 62.

The following F84 diagnosis codes will also be used beginning September 30, 2016 in the MA FFS cost avoidance process to identify claims for the diagnostic assessment and treatment of ASD for children and adolescents under 21:

| ICD-10-CM Diagnosis Codes | |
|---------------------------|--|
| Diagnosis Code | Diagnosis Label |
| F84.0 | Childhood Autism |
| F84.1 | Atypical Autism |
| F84.2 | Rett Syndrome |
| F84.3 | Other Childhood Disintegrative Disorder |
| F84.4 | Overactive Disorder Associated with Mental Retardation and Stereotyped Movements |
| F84.5 | Asperger's Syndrome |
| F84.8 | Other Pervasive Developmental Disorders |
| F84.9 | Pervasive Developmental Disorder, unspecified |

In order to determine if a child or adolescent under 21 years of age has private health insurance coverage and ensure that the MA program is the payer of last resort for claims for services that are for the diagnostic assessment or treatment of ASD, providers must:

Identify Third Party Resources and MA Coverage

- Confirm third party resources by asking MA beneficiaries for all medical insurance cards at the time services are provided and check the Eligibility Verification System (EVS) to identify private health insurance coverage or other third party resources. If there are discrepancies between the medical insurance cards and EVS, providers should confirm private health insurance coverage with the MA beneficiary.
- Confirm MA coverage by checking EVS and identify that MA benefits are provided through either physical health or behavioral health MA MCOs or MA FFS.

If the MA Beneficiary has Private Health Insurance

- Identify the procedure codes that are on the private health insurer's fee schedule. Private health insurance may require specific procedure codes for billing purposes. Those codes should be utilized when billing the primary insurer to ensure proper processing and payment of the claim.
- Submit claims to the private health insurance prior to billing the MA beneficiary's MA MCO or the Department (for MA FFS enrollees) as applicable, even if a denial was previously received for that service or a similar service.

If the MA Beneficiary is in the MA Managed Care Delivery System

- Identify the procedure codes that are on the appropriate physical health or behavioral health MA MCO's fee schedule.

- Submit claims to the appropriate MA MCO based on their claims processing requirements.

If the MA Beneficiary is in the MA FFS Delivery System

- Confirm the procedure codes listed on the MA Program fee schedule. You may view the MA Program fee schedule on line at:
<http://www.dhs.pa.gov/publications/forproviders/schedules/mafeeschedules/index.htm>.
- Submit claims to the Department using procedure codes listed on the MA Program fee schedule, and include the results of billing the private health insurance within your claims:
 - When the private health insurance pays the claim for the ASD service, the provider should include the payment amount.
 - If the private health insurance denies the payment of the ASD service, the provider should provide the following as an attachment:
 - For all claims submitted by paper, the explanation of benefits (EOB) or MA 538/539.
 - For electronic or internet claims, the provider must include the Claim Adjustment Reason Code (CARC).
- If the Department suspends the claim, submit an EOB or letter of denial upon request from the Department. If the EOB contains or letter of denial specifies procedure codes that are different than the procedure code in MA FFS claim, the Department will contact the provider to ensure proper resolution of the claim.

The MA FFS Program will deny claims that do not show the results of billing the private health insurance. Providers may resubmit denied claims to the MA FFS Program with the appropriate documentation/coding within 365 days from the date of service.

For more information on claims processing and cost avoidance, providers should refer to their provider handbook.