

If a conflict arises between a Clinical Payment and Coding Policy (“CPCP”) and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. “Plan documents” include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSIL may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSIL has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act (“HIPAA”) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing (“UB”) Editor, American Medical Association (“AMA”), Current Procedural Terminology (“CPT®”), CPT® Assistant, Healthcare Common Procedure Coding System (“HCPCS”), ICD-10 CM and PCS, National Drug Codes (“NDC”), Diagnosis Related Group (“DRG”) guidelines, Centers for Medicare and Medicaid Services (“CMS”) National Correct Coding Initiative (“NCCI”) Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

## **Applied Behavior Analysis**

**Policy Number: CPCP011**

**Version 3.0**

**Clinical Payment and Coding Policy Committee Approval Date: Nov. 25, 2020**

**Plan Effective Date: Nov. 25, 2020**

## **Description**

The purpose of this document is to clarify the payment policy for covered Applied Behavior Analysis (“ABA”). Health care providers are expected to exercise independent medical judgment in providing care to patients. Services are typically requested for up to 40 hours per week (see Medical Policy PSY 301.021\*). Claims should be coded appropriately per industry standard coding guidelines.

## **Reimbursement Information:**

This policy relates only to the services described herein. Please refer to the Member’s Benefit Booklet for availability of benefits. Member’s benefits may vary according to benefit design; therefore, member benefit language should be reviewed before applying the terms of this policy.

### **Guidelines (unless otherwise provided in the member's benefit):**

- Under medical policy and applicable state mandates, ABA services should only be provided by Qualified Healthcare Provider who is Certified by the Behavior Analyst Certification Board (“BACB”) as a Behavior Analyst and/or licensed in their state as a Licensed Behavior Analyst or Licensed Psychologist. Payer has the option to use provider type modifier.
- ABA services should not be educational, vocational, respite or custodial in nature.
  - Activities primarily of an educational/vocational nature or provided to access a school setting or curriculum that are funded directly or indirectly by a Federal, state or local entity may be excluded from reimbursement under the member's plan. Members are encouraged to seek out government funded vocational training programs, respite services, and/or Individual Education Plan (IEP) services, as such services in academic settings, which are covered under the federal IDEA and FAPE Laws (Individuals with Disabilities Education Act and Free Appropriate Public Education under section 504).
- Reimbursement for programs/services rendered in a non-conventional setting (even if performed by a licensed provider) is subject to medical necessity review by BCBSIL and coverage under the member's plan.
- Approval for payment is only applicable to empirically supported interventions for a current (within 36 months) Autism Spectrum Disorder diagnosis (see Medical Policy PSY 301.021\*).
- The preparation of treatment plans/evaluations (inclusive of time for administration, scoring, interpretation and report write up) should generally be completed within 8 hours (32 units of 97151). Documentation of any units billed beyond that may be subject to medical necessity review and should justify the additional units. CPT code 97151 cannot be reported concurrently with other codes (AMA CPT Coding committee, 2018).
- Parent education is authorized per week for the authorization period (typically 26 weeks) for a total of 26 hours. Requests greater than one hour per week may be reviewed for medical necessity.
- Please refer to the most current release of the Centers for Medicare & Medicaid Services (CMS) Medically Unlikely Edits (MUE) table for guidance on the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. Service units are also limited by specific authorization period.
- CPT Codes 0362T, 0373T involve assessment and direct treatment of severe maladaptive behavior and must be:
  - Administered by the physician or other qualified healthcare professional who is on site;
  - With the assistance of two or more technicians;
  - For a patient who exhibits destructive behavior;
  - Completed in an environment that is customized, to the patient's behavior.

Examples of customized, specialized, and high-intensity settings include a means of separating from other patients, use of protective gear, padded isolation rooms with observation windows

and medical protocols for monitoring patient during and after high intensity episodes, an internal/external review board to examine adverse incidents, access to mechanical/chemical restraint, and frequent external review to determine if the patient needs a higher level of care and whether this patient be safely treated in an outpatient setting. This service may be provided in day treatment, intensive outpatient day treatment or inpatient facilities, depending on the behavior. These services are not reimbursable, so providers should bill for encounter data purposes only.

- CPT code 97156 (Family Adaptive Behavior Treatment Guidance) is expressly for the QHP to meet face-to-face with the guardians/caregivers of the patient (with or without the patient present). This code should be reported when engaging in this activity rather than 97155, which is reserved for meetings with the patient.
- CPT codes are face to face and with one patient unless otherwise specified in the description. Billable supervision of a patient must be face to face and involves only one technician. There is no CPT code for indirect (patient not present) supervision activities (other than report writing- 97151 and family adaptive behavior treatment guidance- 97156).
- Documentation required to substantiate that services were rendered include but are not limited to: (1) a parent or caregiver's signature for each rendered service that also includes the service/code provided, rendering provider's name/signature, the date of service, and the beginning/end times of the service, (2) a written account, summary, or note of the service rendered, and (3) data point(s) regarding the Member's progress for the day.
- Case Supervision activities are comprised of both direct supervision (patient present) and indirect supervision (patient not present). Direct supervision includes direction of Registered Behavior Technicians, treatment planning/monitoring fidelity of implementation, and protocol modification. Whereas indirect supervision includes developing treatment goals, summarizing and analyzing data, coordination of care with other professionals, report progress towards treatment goals, develop and oversee transition/discharge plan, and training and directing staff on implementation of new/revised treatment protocols (patient not present). The AMA codes for Adaptive Behavior Services indicate that the activities associated with indirect supervision are bundled codes and are otherwise considered a practice expense and not reimbursable. Although indirect supervision is a practice expense, documentation in the treatment plan of this service occurring is expected. The BACB (2014, pp. 31) recommends 20% of direct hours be spent in "Case Supervision activities" [both indirect and direct supervision combined] and 50% of this time be used for direct supervision. Direct supervision will be authorized at a minimum of 1 hour per week when less than 10 hours of direct services are authorized.
- To date, there is no empirical support that short-term, intermittent, high-intensity ABA programs (summer months only) result in long-term optimal treatment outcome efficacy [9]. Further, medically necessary ABA is not a replacement for the structure and routine of school or custodial care of the member. Additionally, "wrap-around services" are not empirically supported nor the first line treatment for Autism Spectrum disorders.
- Research on social skills training in group settings has been limited to specific protocol used in durations ranging from 30 minutes to 120 minutes per day for 36 weeks [14-23]. There should be

specific goals and planned programming to support group treatment requests. Group treatment is not intended to capture time spent during meals and breaks from ABA treatment.

- Direct treatment by QHP (97152, 97153 or 97154). If the QHP “personally performs the technician activities, his or her time engaged in these activities should be reported as technician time.” (AMA CPT Coding committee, 2018 pp 711)
- CPT codes 97154 and 97158 refer to group interventions. Groups must contain no fewer than 2 members and no more than 8 members (AMA CPT Coding Committee, 2018).
- Use a single modifier to indicate the level of education, training, and certification of the rendering provider of the 97153 codes.

**Reporting units for timed codes:** When multiple units of therapies or modalities are provided, the 8-minute rule must be followed when billing for these services. A provider should not report a direct treatment service if only one attended modality or therapeutic procedure is provided in a day and the procedure is performed for less than 8 minutes.

- The time reported should be the time actually spent in the delivery of the modality and/or therapeutic procedure. This means that pre and post-delivery services should not be counted in determining the treatment time.
- The time that the patient spends not being treated, due to resting periods or waiting for a piece of equipment to become available, is not considered treatment time.
- All treatment time, including the beginning and ending time of the direct treatment, must be recorded in the patient’s medical record, along with the note describing the specific modality or procedure.

The following unit of service billing guideline has been published by Medicare. It is the standard when billing multiple units of service with timed procedures defined as per each 15 minutes.

- unit: ≥ 8 minutes through 22 minutes
- units: ≥ 23 minutes through 37 minutes
- units: ≥ 38 minutes through 52 minutes
- units: ≥ 53 minutes through 67 minutes
- units: ≥ 68 minutes through 82 minutes
- units: ≥ 83 minutes through 97 minutes
- units: ≥ 98 minutes through 112 minutes
- units: ≥ 113 minutes through 127 minutes

If any 15-minute timed service that is performed for 7 minutes or less on the same day as another 15-minute timed service that was also performed for 7 minutes or less and the total time of the two is 8 minutes or greater, then bill one unit for the service performed for the most minutes. The same logic is applied when three or more different services are provided for 7 minutes or less.

For example, if a provider renders:

- 5 minutes of 97035 (ultrasound),
- 6 minutes of 97110 (therapeutic procedure), and
- 7 minutes of 97140 (manual therapy techniques)

Then claim should be filed with 1 unit of 97140 since the total minutes of direct treatment is 18 minutes. The patient's medical record should document that all three modalities and procedures were rendered and include the direct treatment time for each.

If any direct patient contact timed service is performed on the same day as another direct patient contact timed service, then the total units billed cannot exceed the total treatment time for these services.

For example, if a provider renders:

- 8 minutes of 97530 (therapeutic activities),
- 8 minutes of 97110 (therapeutic procedure), and
- 8 minutes of 97140 (manual therapy techniques)

Then claim should be filed with a total of 2 units since the total minutes of direct treatment is 24 minutes. The patient's medical record should document that all three modalities and procedures were rendered and include the direct treatment time for each.

The following procedural codes serve as guidelines for the billing of Applied Behavior Analysis services:

<b>CPT Code</b>	<b>Guideline</b>
0362T	BHV ID SUPRT ASSMT EA 15 MIN
0373T	ADAPT BHV TX EA 15 MIN
97151	BHV ID ASSMT BY PHYS/QHP
97152	BHV ID SUPRT ASSMT BY 1 TECH
97153	ADAPTIVE BEHAVIOR TX BY TECH
97154	GRP ADAPT BHV TX BY TECH
97155	ADAPT BEHAVIOR TX PHYS/QHP
97156	FAM ADAPT BHV TX GDN PHY/QHP
97157	MULT FAM ADAPT BHV TX GDN
97158	GRP ADAPT BHV TX BY PHY/QHP

## \*References: Medical Policies

<b>Title</b>	<b>Policy Number</b>
Applied Behavior Analysis (ABA)	<b>PSY301.021</b>

## References:

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**Policy Update History:**

Approval Date	Description
04/30/2018	New policy
02/22/2019	Coding updates
03/06/2020	Annual Review, Disclaimer Update
11/25/2020	Removed Telemedicine verbiage