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. BCBSNM may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSNM 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 1.0

Clinical Payment and Coding Policy Committee Approval Date: May 23, 2023

Plan Effective Date: May 30, 2023

Description

This policy was created to serve as a general reference on the reimbursement for covered Applied Behavior Analysis (ABA) services. Health care providers are expected to exercise independent medical judgment in providing care to patients. CMS Medically Unlikely Edits (MUE) indicate that direct services are typically requested for up to 40 hours per week. Claims should be coded appropriately per industry standard coding guidelines.

Reimbursement Information:

<u>Guidelines</u> (unless otherwise provided in the member's benefit):

Consistent with plan medical policy PSY301.021 Applied Behavior Analysis (ABA) for Autism Spectrum Disorder (ASD) Diagnosis, and applicable state mandates:

- ABA services are not reimbursable to providers if the services are not provided by a Qualified Healthcare Professional (QHP) 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.
- Reimbursement to providers is not available for ABA services that are provided for educational, vocational, respite or custodial purposes.
- Coverage for programs/services rendered in a non-conventional setting, such as anything other than Place of Service (POS) codes 10, 11, and 12, even if performed by a licensed provider, are subject to the terms of a member's coverage and medical necessity review by the plan.
- The Plan recommends that all treatment plans and/or evaluations (inclusive of time for administration, scoring, interpretation, and report write up) should be completed within 8 hours (32 units of 97151) or the services may not be eligible for reimbursement to the provider per industry standard coding guidelines.
- Consistent with practitioner guidelines (CASP, 2014), 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 outside of the member's coverage limitations.
- 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.
- Documentation of any units billed beyond industry standard coding guidelines should justify any additional units billed. CPT code 97151 cannot be reported concurrently with other codes.
- CPT Codes 0362T and 0373T involve assessment and direct treatment of severe maladaptive behavior and, this service should have defined treatment protocols that are separate and distinct from a patient's other treatment protocols. Consistent with American Medical Association CPT Coding Committee (2022) 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. Alternatively, this level of support may be provided utilizing different funding in day treatment, or different procedural codes for intensive outpatient day treatment or inpatient facilities, depending on the behavior.

- 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 or week-to-week treatment planning. (The only codes that allow for the patient not present are assessment/reassessment report writing CPT code 97151, and family adaptive behavior treatment guidance CPT code 97156).

- ABA services provided via Telemedicine/Telehealth are subject to the terms of CPCP033 Telemedicine and Telehealth Services.

- Documentation is 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, certification and credentials, place of service, 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, may be required immediately after the service occurred and for the purposes of audit.

- Consistent with practitioner guidelines (CASP, 2014), 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 are not eligible for separate reimbursement. Although indirect supervision is a practice expense, documentation in the treatment plan of this service occurring is expected by the Plan even though it is not reimbursable by the Plan (CASP 2020, 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 may be authorized for coverage consistent with the member's benefits at a minimum of 1 hour per week when less than 10 hours of direct services are authorized.

- Direct treatment by a QHP (CPT codes 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, 2022)
- CPT codes 97154 and 97158 refer to group interventions. Groups must contain no fewer than 2 members and no more than 8 members. QHP direction of the technician as they render 97154 would be captured as code 97155. QHP directly rendering group treatment with protocol modification would be captured as 97158.
- Use a single modifier (HM, HN, HO) to indicate the level of education, training, and certification of the rendering provider when CPT code 97153 is submitted.
- The provider who renders treatment week to week to the member is considered the 'rendering provider' and should bill for the services provided. A provider who is not rendering protocol modification, parent education, assessment or report writing services should not bill for services that they did not personally provide. An unlicensed, non-network-credentialed, and otherwise non-qualified provider cannot provide services and bill through another person's NPI number and receive reimbursement from the Plan.
- All Covered Services provided for and billed for by the Plan's members by Contracting Provider shall be performed personally by the Contracting Provider or under that provider's direct and personal supervision and in the provider's presence, except as otherwise authorized and communicated by the Plan. Direct personal supervision requires that a Contracted Provider be in the immediate vicinity to perform or to manage the procedure personally, if necessary.
- There may be times when it is clinically indicated to provide co-treatment with another distinct service, such as Speech Therapy or Occupational Therapy. Such co-treat sessions is generally for the purpose of addressing defined behavioral or skills deficits present and should be documented in the treatment plan as such. Co-treat sessions should be billed with the appropriate modifier.

Reporting units for timed codes: In order to be reimbursable, when multiple units of therapies or modalities are provided, the 8-minute rule must be followed when billing for these services. In order to be eligible for reimbursement, 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 CPT code 97035 (ultrasound),
- 6 minutes of CPT code 97110 (therapeutic procedure), and
- 7 minutes of CPT code 97140 (manual therapy techniques)

Then the claim should be filed with 1 unit of CPT code 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 CPT code 97530 (therapeutic activities),
- 8 minutes of CPT code 97110 (therapeutic procedure), and
- 8 minutes of CPT code 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 is not an all-encompassing coding list. The inclusion of a code below does not guarantee it is a covered service or eligible for reimbursement. Exclusions may apply under benefit plans or other plan documents.

CPT Code	Guideline
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

Additional Resources:

Medical Policy

PSY301.021 Applied Behavior Analysis (ABA) for Autism Spectrum Disorder (ASD) Diagnosis

Clinical Payment and Coding Policy

CPCP023 Modifier Reference Policy

CPCP033 Telemedicine and Telehealth Services

References:

1. American Medical Association CPT Coding Committee (2022). 2022 CPT Professional Codebook. Chicago, Il: American Medical Association Publishing
2. American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders, (5th Ed.). Arlington, VA: American Psychiatric Publishing.
3. Counsel of Autism Service Providers (2020). Applied Behavior Analysis Treatment for Autism Spectrum Disorders: Guidelines for Healthcare Funders and Managers. Littleton, CO: Author. Available at https://casproviders.org/asd-guidelines
4. Centers for Medicare & Medicaid Services (CMS) Medically Unlikely Edits (MUE) table (effective 1/1/2019). Available at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html (accessed 2018 April 11).
5. New Mexico Human Services Department (2014). State of New Mexico. Medical Assistance Program Medical Assistance Division Billing Instructions. Retrieved from http://www.hsd.state.nm.us/providers/provider-packets.aspx

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
11/09/2021	Annual Review
5/23/2023	Annual Review