



Model Coverage Policy

for Adaptive Behavior Services

Overview

This document is a model health insurance coverage policy. It was developed in 2020 by the ABA Coding Coalition (representatives of the Association of Professional Behavior Analysts, Autism Speaks, Behavior Analyst Certification Board, Council of Autism Service Providers, and their CPT® consultant). The Coalition comprises most of the individuals and organizations who authored the application that was submitted to the American Medical Association in 2016 to obtain Category I CPT® codes for adaptive behavior (applied behavior analysis; ABA) assessment and treatment services.

The purpose of this model coverage policy is to help providers of ABA services communicate with payers about appropriate coverage determinations, including indications, limitations, and competence recommendations. Providers may use this document in conversations with Medicaid, Medicare, TRICARE, and commercial payers. Many commercial payers have national policies, but several have local discretion. At present there is considerable variability across payers in policies regarding these services. We encourage use of this model coverage policy to enhance consistency in the coverage of ABA services.

If you have questions regarding this model coverage policy or the 2019 CPT® codes for adaptive behavior services, please feel free to contact the ABA Coding Coalition at <https://abacodes.org/contact/>

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Sample Coverage Policy

Contractor Name

Contractor Number

Contractor Type

LCD Database ID Number

LCD Title: Adaptive Behavior Services

AMA CPT Copyright Statement

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CMS National Coverage Policies

Title XVIII of the Social Security Act, Section 1862 (a)(1)(A)

This section allows coverage and payment only for services considered medically reasonable and necessary.

Title XVIII of the Social Security Act, Section 1833 (e)

This section prohibits Medicare payment for any claim that lacks the necessary information to process the claim.

CMS Manual System, Pub 100-9, Contractor Beneficiary and Provider #9; Communication Manual, Chapter 5, Section 20).

This section addresses standards of medical/surgical practice and the correct coding initiative (CCI).

42 CFR Part 441, Subpart B - Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under Age 21.

This benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services.

CMS Informational Bulletin, Clarification of Medicaid Coverage of Services to Children with Autism. July 7, 2014.

This Bulletin clarified that EPSDT services must be made available to eligible children with Autism Spectrum Disorder.

Primary Geographic Jurisdiction

Oversight Region

CMS Consortium

Original Determination Effective Date

Original Determination Ending Date

Revision Effective Date

Revision Ending Date

Indications

Behavior analysis is a natural science discipline whose subject matter is behavior interacting with environmental events. Applied behavior analysis (ABA) involves applying scientific principles and procedures discovered through basic and applied research to improve socially important behaviors to a meaningful degree. Extensive research conducted since the 1960s has documented the efficacy of scores of ABA procedures – singly and in various combinations – for building useful skills and reducing problem behaviors in many clinical and nonclinical populations.

In particular, when designed and overseen by qualified professionals, ABA treatments have proved effective for ameliorating symptoms, developing adaptive behaviors, and reducing maladaptive behaviors so as to enhance healthy, successful functioning and prevent deterioration and regression in patients with disorders that arise during the developmental period. Those include but are not limited to autism spectrum disorder, intellectual and other developmental disabilities, attention-deficit/hyperactivity disorder, brain injuries and diseases, movement disorders, feeding disorders, and behavior disorders. Examples of adaptive behaviors include social, communication, cognitive, leisure, self-care, daily living, vocational, and personal safety skills. Maladaptive behaviors that have been treated effectively with ABA procedures include self-injury, property destruction, pica (ingesting inedible items), aggression, elopement (wandering), obsessive behaviors, hyperactivity, and fearful behaviors.

ABA treatments may be focused (addressing a small number of adaptive and/or maladaptive behaviors) or comprehensive (addressing a large number of adaptive behaviors in multiple domains as well as maladaptive behaviors). In either case, the services have the following core elements:

- Comprehensive assessment that describes specific levels of behavior at baseline and informs selection of treatment goals
- An emphasis on understanding the current and future value (or social importance) of behavior(s) targeted for treatment
- A focus on establishing small units of behavior that are built systematically toward larger changes to improve health, safety, and independent functioning
- Ongoing collection, quantification, and analysis of graphed direct observational data on all treatment targets
- Efforts to design, establish, and manage social and learning environment(s) to minimize maladaptive behavior(s) and maximize progress toward all goals
- An approach to the treatment of maladaptive behavior that links treatment procedures to the function of (the reason for) the behavior
- Development of a carefully constructed, individualized and detailed treatment plan that utilizes reinforcement and other behavior-analytic procedures and excludes the use of procedures that lack scientific evidence of effectiveness
- Use of written treatment protocols that are implemented repeatedly, frequently, and consistently in multiple settings. Protocols may be implemented by the professional behavior analyst and/or by assistant behavior analysts, behavior technicians, interns and other trainees, and/or family members who are trained and overseen by the professional.
- Support and training of family members and other caregivers to promote generalization and maintenance of behavioral improvements, to the extent that is practical given family circumstances

- Ongoing careful case supervision¹ and clinical direction² by a professional behavior analyst that includes but is not limited to coordinating care with other providers; directing the implementation of the treatment plan by behavior technicians, caregivers, and other supervisees; reviewing patient progress data frequently; and modifying treatment protocols and the treatment plan as indicated by the data

General coverage requirements

Services must be medically necessary to ameliorate symptoms of a diagnosed disorder, build adaptive behaviors, and/or reduce maladaptive behaviors to enhance the patient’s health, safety, and overall functioning and/or to prevent deterioration or regression.

CMS defines medical necessity as healthcare services or supplies that are needed to diagnose or treat an illness or injury, condition, disease, or its symptoms. The services or supplies must also meet accepted medical standards. Medicaid’s Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program provides a comprehensive array of prevention, diagnostic, and treatment services for eligible infants, children, and adolescents under age 21, as specified in Section 1905(r) of the Social Security Act (the Act). The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure early detection and care so that a child’s health problems are averted or diagnosed and treated as early as possible. The goal of EPSDT is to assure that individual children get the health care they need when they need it – “the right care to the right child at the right time in the right setting.”³

Under EPSDT, Medicaid covers medically necessary services for identified physical, dental, developmental, and mental health conditions. That includes all medically necessary services in the categories of mandatory and optional services defined in Medicaid law section 1905(a), regardless of whether a state chooses to cover such services for adults and elderly. Some examples of covered services for children include:

- preventive visits
- mental and behavioral health services
- case management
- speech-language-hearing, occupational, and physical therapy
- eyeglasses, hearing aids, and augmentative communication devices
- dental care
- medical equipment and supplies

1 “**Supervision**” of a technician or other employee by a qualified health care provider (QHP) generally refers to processes through which the QHP ensures that the supervisee (a) practices in a competent, professional, and ethical manner in accordance with the standards of the profession; (b) engages with and follows the employer’s policies and procedures; (c) continues to develop their knowledge and skills; and (d) receives the personal support needed to cope with the stressors and demands of their position. “Supervision” may also involve activities to enable the supervisor and supervisee to comply with specific requirements for obtaining or maintaining a paraprofessional or professional credential, such as a certification or license, or to fulfill ethical responsibilities. “**Case supervision**” as the term is used in behavior analysis refers to the work conducted by the behavior analyst to develop, deliver, and oversee implementation of a patient’s treatment plan. It encompasses both direct contact with the patient or caregivers and indirect services. Supervision activities that do not involve delivery of services directly to patients are generally not reportable or billable to health plans using CPT codes (except code 97151), though some payers may allow them to be billed using HCPCS or other codes. Those that do involve direct delivery of services to maximize benefits to individual patients may be reportable and billable to a health plan and fulfill some supervision requirements for certification or licensure purposes, but only the former should be reported to the health plan.

2 “**Clinical direction**” or “**direction**” refers to the QHP directly monitoring the delivery of treatment to a patient by a behavior technician. The focus is on ensuring that treatment protocols are implemented correctly in order to maximize benefit to that patient. Direction of a technician includes, but is not limited to, the QHP frequently observing the technician implementing the patient’s protocols with the patient, providing instructions and confirming or corrective feedback as needed, and/or demonstrating correct implementation of a new or modified treatment protocol with the patient while the technician observes, followed by the technician implementing the protocol with the patient while the QHP observes and provides feedback.

3 <https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html>

- school-based health services
- therapeutic child care
- personal care services
- rehabilitation services
- nutritional supplements/medical foods

For Medicaid beneficiaries, determinations of medical necessity are made by the state Medicaid agency or by the health plan that has been delegated that authority by the state agency, and must be made on a case-by-case basis, taking into account the particular needs of the individual patient and guided by information from the patient's healthcare providers. Hard, fixed, or arbitrary limits (e.g., based on dollar amounts, standard deviations from the norm, lists of diseases) are not permitted. State Medicaid agencies may set limits for an individual. For example, the state cannot limit physical therapy visits to 12 per year for all children under EPSDT as an arbitrary cap on such services, but might determine that an individual child needs only 12 monthly visits in a year. Services may be (a) necessary to prevent further advancement of a condition (maintenance or control); (b) ameliorative; or (c) corrective, as when services help a child reach the age-appropriate developmental level.

Determinations of medical necessity for beneficiaries of commercial and other health plans must also be individualized to the patient based on information like that just described.

Service authorizations

Authorization periods should not be for less than 6 months and may involve some or all of the services listed below. If third-party clinical review (also known as peer review) is required by a healthcare funder or manager, the reviewer should be a credentialed professional behavior analyst who has experience in treating patients like the one that is the focus of the review.

The following services should be authorized for optimal treatment outcomes. Others may be appropriate.

- Behavior-analytic assessment
- Treatment plan development and modification
- Direct treatment to individuals or groups with implementation by behavior analysts and/or behavior technicians
- Case supervision (both direct and indirect) and clinical direction by behavior analysts
- Travel to ensure equitable access to services (for example, in rural and underserved areas)
- Parent and community caregiver training to individuals or groups
- Consultation to ensure continuity and/or coordination of care
- Discharge planning

Approved providers

- Licensed Behavior Analysts (in states with behavior analyst licensure laws)
- Board Certified Behavior Analysts-Doctoral™
- Board Certified Behavior Analysts®
- Licensed psychologists where behavior analysis is in the psychology scope of practice definition in the state psychology licensure law and in the scope of the licensee's education, training, and competence

The American Medical Association (AMA) defines a qualified healthcare professional (QHP) for purposes of reporting medical services as follows: "A 'physician or other qualified health care professional' is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service." The professionals listed above are credentialed to practice independently. They may be assisted by Licensed Assistant Behavior Analysts (where applicable) or Board Certified Assistant Behavior Analysts® and behavior technicians (paraprofessionals) who implement treatment plans under the supervision of professional behavior analysts.

Treatment models

ABA treatment programs are derived from the results of thousands of applied studies published in peer-reviewed journals over a 50-year span. Treatment may vary in intensity, duration, the complexity and range of treatment goals, the extent of direct treatment provided, and other dimensions. Although there is a continuum of ABA treatments, they can generally be categorized as focused or comprehensive. Many variables -- including the number, nature, and complexity of behavioral targets and the patient's history and response to treatment -- determine which model is appropriate.

1. *Focused ABA treatment.* This refers to treatment provided directly to the patient for a limited number of behavioral targets. It is not restricted by age, cognitive level, diagnosis, or co-occurring conditions. Focused ABA treatment may aim primarily to increase adaptive behaviors (e.g., communication, social initiations), reduce problem behaviors (e.g., elopement, aggression), or both. When reduction of problem behavior is the primary goal, it is critical to also target increases in alternative adaptive behavior, because the absence of adaptive behavior is often the precursor to serious behavior disorders. Therefore, focused ABA treatments are also appropriate for patients who need to acquire adaptive skills (e.g., communication, tolerating change in environments and activities, self-help, social).

Focused ABA treatment plans are appropriate for patients who (a) need treatment only to develop a limited number of key functional skills or (b) have such risky problem behavior that its treatment should be the priority. Examples of key functional skills include, but are not limited to, instruction-following, social skills, communication skills, compliance with medical and dental procedures, sleep hygiene, self-care skills, safety skills, and independent leisure skills (for example, appropriate participation in family and community activities). Examples of problem behaviors requiring focused intervention include, but are not limited to, self-injury, aggression, threats, pica, elopement, feeding disorders, stereotypic motor or vocal behavior, property destruction, noncompliance, disruptive behavior, and dysfunctional social behavior.

In prioritizing treatment targets, the following should be considered:

- Behavior that threatens the health or safety of the patient or others or that constitutes a barrier to quality of life (e.g., severe aggression, self-injury, property destruction, elopement, or noncompliance)
- Absence of adaptive, social, or functional skills that are fundamental to health, safety, social inclusion, and independence (e.g., toileting, dressing, feeding, and compliance with medical procedures).

When the primary focus of treatment is increasing socially appropriate behavior, services may be delivered in either an individual or small-group format. In small-group treatment for patients with developmental disorders, typically developing peers or individuals with similar diagnoses may participate in sessions. Members of the ABA treatment team typically guide patients through the rehearsal and practice of behavioral targets with each other. As is the case for all treatments, programming for generalization of skills outside of formal treatment sessions is critical.

When the primary focus of treatment is the reduction of problem behavior, the behavior analyst identifies situations that are likely to precipitate problem behavior in order to identify its purpose (“function” in behavior analytic terms). That may require conducting a functional analysis – a specific type of assessment procedure that involves systematically testing the effects of environmental events on the behavior of interest. When the function of the problem behavior has been identified, the behavior analyst designs a treatment plan that alters the environment to reduce the motivation for problem behavior and/or establish an alternative adaptive behavior.

Some patients display severe problem behaviors that require focused treatment in specialized intensive outpatient, day treatment, residential, or inpatient programs. In some cases the behavior disorders are given separate and distinct diagnoses (for example, stereotypic movement disorder with severe self-injurious behavior). The ABA services delivered in specialized settings typically require high staff-to-patient ratios (e.g., 2 - 3 staff for each patient) and close on-site direction by the behavior analyst. They may also require specialized treatment environments (e.g., rooms designed for observation and to keep the patient and the staff as safe as possible).

2. *Comprehensive ABA treatment.* In this model, behaviors in multiple affected domains (cognitive, communicative, social, self-care, leisure, etc.) are targeted for treatment, often along with maladaptive behaviors such as tantrums, elopement, pica, self-injury, and stereotypy. One example is early intensive ABA treatment for children with autism and related disorders where the overarching goal is to close the gap between the patient’s current level of functioning and that of their typically developing peers. Comprehensive treatment may also be appropriate for patients who engage in harmful and risky behaviors and/or have substantial deficits in adaptive skills that jeopardize their health and safety. Comprehensive ABA programs often involve 30 - 40 hours of treatment per week (plus direct and indirect case supervision and caregiver training). Treatment may be 1:1 initially with gradual transitions to small-group formats as appropriate. Initially, treatment may be provided primarily in structured sessions, but more naturalistic methods are also used as appropriate. As the patient progresses and meets criteria, treatments may be provided in multiple different settings.

3. *Variations in treatment models.* As noted previously, ABA treatment programs vary along several dimensions, including intensity and duration. Other variations include the extent to which peers or caregivers are involved in the delivery of treatment. Decisions about how those and other dimensions are incorporated within individual treatment plans must reflect many variables, including the research evidence, patient age and functional levels, characteristics of target behaviors, the patient’s rate of progress, caregiver circumstances and skills, and resources required to implement the treatment plan across settings.

ABA procedures

A large array of ABA procedures has proved effective for developing adaptive behaviors and reducing maladaptive behaviors. All of the procedures are based on the principles of behavior analysis. They include but are not limited to different types of schedules of reinforcement, differential reinforcement, shaping, chaining, behavioral momentum, prompting and prompt fading, behavioral skills training, extinction, functional communication training, discrete-trial procedures, incidental teaching, self-management, functional assessment, preference assessments, activity schedules, generalization and maintenance procedures, and many others. The discipline of behavior analysis is constantly developing and evaluating applied behavior-change procedures. The behavior analyst selects the procedures to incorporate in each individual patient’s treatment plan based on results of

assessments, interviews with caregivers and the patient, considerations of environmental factors, and input from other professionals as appropriate. The procedures are employed with flexibility based on frequent, ongoing direct observation and measurement of the targets in the patient's treatment plan and analysis of the resulting graphed data. If the data indicate that a procedure or combination of procedures is not producing the desired results, the procedures are modified or replaced.

Treatment settings

Regardless of whether they are focused or comprehensive, ABA treatments may be delivered in a variety of settings, including but not limited to residential programs, assisted living facilities, group homes, inpatient and outpatient programs, family homes, schools, hospitals, clinics, centers, workplaces, and various locations in the patient's community. Treatment across settings and people (interventionists, peers, siblings, coworkers) is necessary to promote generalization and maintenance of treatment gains. It should be noted that treatment might occur in multiple settings (e.g., home, community, and work) on the same day. Treatment should not be denied or withheld based on caregiver availability. To ensure continuity of care and maintenance of gains after discharge from formal treatment, ABA services should be delivered in subsequent settings (e.g., residence to school, clinic to home).

Patient age

Treatment should be based on medical necessity for each individual patient and not constrained by age. Consistent ABA treatment should be provided as soon as possible after diagnosis, and in some cases prior to diagnosis. There is evidence that for children diagnosed with autism and other developmental disorders, intensive and comprehensive ABA treatment tends to be more effective when it begins prior to age 8 than later, but research has not established an age limit beyond which ABA treatments are ineffective. On the contrary, there is abundant evidence that a wide array of ABA treatment procedures is effective for building adaptive skills and reducing maladaptive behaviors throughout the lifespan.

Treatment dosage

The dosage of ABA treatment will vary with each patient and should reflect the goals of treatment, patient strengths and needs, patient and caregiver circumstances and preferences, available resources, and the patient's response to treatment. Treatment dosage should encompass both intensity and duration.

Intensity is typically measured in terms of number of hours per week of direct treatment. Focused ABA treatment generally requires 10 - 25 hours per week of direct treatment (plus direct and indirect clinical direction and caregiver training). However, treatment of severe problem behavior (for example, day or inpatient treatment of self-injurious behavior) or substantial deficits in adaptive behaviors may require more than 25 hours per week.

Comprehensive treatment often involves 30 - 40 hours of direct treatment to the patient per week, not including caregiver training, case supervision and clinical direction by the behavior analyst, and other needed services. Some patients (e.g., very young children, elders) may start with a few hours of treatment per day, with the goal of increasing the intensity as their ability to participate permits. Treatment hours should be increased or decreased based on the patient's response to treatment and current needs. Hours may be increased as needed to reach treatment goals efficiently. Decreases in hours of treatment per week typically occur when a patient has met most treatment goals and is moving toward discharge or transition to a different treatment model or program.

The recommended intensity level for comprehensive ABA treatment is based on research regarding the number of hours of treatment per week required to produce good outcomes for young children with developmental disorders. It should be noted that lower-intensity treatment, delays in commencing treatment, and interruptions in treatment may result in patients deteriorating or regressing. That will likely result in increased healthcare costs and greater dependence on more intensive services across the lifespan for those patients.

Treatment *duration* is managed by evaluating the relevant research evidence and each patient's response to treatment. Rates of progress and treatment duration can vary substantially across individuals. The evaluation can be conducted prior to the conclusion of an authorization period. For some patients, ABA services will continue to be medically necessary across multiple authorization periods.

Components of a treatment plan

The treatment plan must be individualized to the patient and their caregivers and must include:

- I. Patient information
- II. Reason for referral
- III. Brief background information
- IV. Clinical interview
- V. Review of recent assessments/reports (file review)
- VI. Assessment procedures and results
- VII. Treatment plan
 - a. Treatment setting(s)
 - b. Proposed treatment targets, goals, and objectives. For each:
 1. Definition in observable, measurable terms
 2. Direct observation and measurement procedures
 3. Current level (baseline)
 - c. Behavior reduction and/or acquisition procedures
 1. Condition(s) under which behavior is to be demonstrated and mastery criteria
 2. Date of introduction
 3. Estimated date of mastery
 4. Plan for generalization
 5. For progress reports, statement as to whether goal or objective is met, not met, or modified (with explanation)
- VIII. Parent/caregiver training (where medically necessary and to the extent practical)
 - a. Proposed targets, goals, and objectives (as above)
 - b. Training procedures
 - c. Date of introduction
 - d. Estimated date of mastery
- IX. Number of hours or units requested
 - a. Direct services to patient
 - b. Parent/caregiver training
 - c. Clinical direction
 - d. Case supervision
 - e. For each:
 1. Medical necessity for hours/units requested
 2. Billing codes (CPT, HCPCS) and modifiers if applicable
- X. Coordination of care (where applicable)
- XI. Transition plan
- XII. Discharge plan
- XIII. Crisis management plan (where applicable)

Dosage of case supervision

Although the amount of case supervision and direction of technicians⁴ by the behavior analyst must be responsive to individual patient needs, 2 hours for every 10 hours of direct treatment is the general standard of care. When direct treatment occurs for 10 hours per week or less, a minimum of 2 hours per week of case supervision is generally required. Case supervision may need to be increased temporarily to meet a patient's needs at specific points in treatment (for example, initial assessment, significant change in treatment targets).

The ratio of case supervision hours to direct treatment hours should reflect the complexity of the patient's treatment program and the responsive, individualized, data-based decision-making that characterizes ABA treatment. A number of factors increase or decrease case supervision needs on a shorter- or longer-term basis. They include:

- treatment dosage/intensity
- barriers to progress
- issues of patient health and safety (for example, certain skill deficits, dangerous problem behavior)
- the sophistication or complexity of treatment protocols
- family dynamics or community environment
- lack of progress or increased rate of progress
- changes in treatment protocols
- transitions with implications for continuity of care

The proportion of case supervision hours to direct treatment hours is a general parameter that should not be interpreted or applied rigidly. Instead, if the professional behavior analyst determines that X number of hours per week of case supervision is required, that is the number of hours that should be authorized, with the understanding that the number may need to be adjusted up or down over the course of treatment. Further, those hours must not be counted toward, substituted for, or offset against the hours of ABA treatment delivered directly to the patient.

Caseload size

Behavior analysts should carry a caseload that allows them to provide appropriate case supervision to ensure effective treatment delivery and consumer protection. Caseload size for the behavior analyst is typically determined by the following factors:

- complexity and needs of the patients in the caseload
- total treatment hours delivered to the patients in the caseload
- total case supervision and clinical direction required by the caseload

⁴ “**Direction**” in this context refers to the QHP directly monitoring the delivery of treatment to a patient by a behavior technician (CPT 97155). The focus is on ensuring that treatment protocols are implemented correctly in order to maximize benefit to that patient. Direction of a technician includes, but is not limited to, the QHP frequently observing the technician implementing the patient's protocols with the patient, providing instructions and confirming or corrective feedback as needed, and/or demonstrating correct implementation of a new or modified treatment protocol with the patient while the technician observes, followed by the technician implementing the protocol with the patient while the QHP observes and provides feedback. That service should be reported and billed using code 97155 (adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional). The technician's time is separately reportable under 97153 (adaptive behavior treatment by protocol administered by technician under the direction of a physician or other qualified health care professional). Time reported and billed must be face-to-face time with the patient.

- expertise and skills of the behavior analyst
- location and modality of supervision and treatment (e.g., center vs. home, individual vs. group, telehealth vs. in vivo)
- availability of support staff for the behavior analyst (e.g., an assistant behavior analyst)

The recommended caseload ranges for one behavior analyst supervising focused treatment cases are

- *without support of an assistant behavior analyst:* 10 - 15.
- *with support of one (1) assistant behavior analyst:* 16 - 24.

The recommended caseload ranges for one behavior analyst supervising comprehensive treatment cases are

- *without support of an assistant behavior analyst:* 6 - 12.
- *with support of n) assistant behavior analyst:* 12 - 16.

Additional assistant behavior analysts permit modest increases in caseloads. Treatment for severe problem behavior is complex and requires considerably greater levels of case supervision, which necessitates smaller caseloads.

Caregivers as important contributors to outcomes

Family members (including siblings) and other caregivers should be included in various capacities and at different points during ABA treatment. In addition to providing important historical and contextual information and input on important treatment targets, caregivers should receive training and consultation throughout treatment, discharge, and followup to the extent practical.

Family dynamics and how they are affected by the patient's needs must be reflected in treatment planning and delivery. In addition, the patient's progress may be affected by the extent to which caregivers implement treatment procedures outside of treatment hours. Their ability to do so is determined in part by how closely treatment goals and protocols match the caregivers' values, needs, priorities, skills, preferences, and resources.

The need for caregiver involvement, training, and support reflects the following:

- Caregivers frequently have unique information and perspectives about the patient's functioning, preferences, and behavioral history.
- Caregivers may be responsible for provision of care, supervision, and dealing with maladaptive behaviors during all the patient's waking hours outside of formal treatment. That often presents many challenges.
- Studies have shown that parents of individuals with disabilities experience higher levels of stress than parents of typically developing children or children with other kinds of special needs.
- Behavioral problems often present particular challenges for caregivers. Typical parenting strategies may be insufficient for managing them, which can impede the patient's progress towards improved levels of functioning and independence and increase caregiver stress.

Caregiver training is an important component of both focused and comprehensive ABA treatments. Although it is sometimes delivered as a stand-alone service, there are relatively few patients for whom caregiver training should be recommended as the sole or primary form of treatment for patients who exhibit maladaptive behaviors or substantial deficits in adaptive behaviors.

It is common for ABA treatment plans to include several objective and measurable goals for caregivers. Training emphasizes skill development to enable caregivers to become competent in implementing selected treatment protocols across environments. It usually involves an individualized behavioral assessment, a case formulation, customized didactic presentations, modeling of target skills, and practice with feedback and coaching from the behavior analyst. Ongoing supervision and coaching while the caregiver implements protocols with the patient, problem-solving as issues arise, and support for implementation of strategies in new environments are required to ensure optimal gains by the patient and to promote generalization and maintenance of therapeutic changes. Simply having the caregiver observe the implementation of protocols by a behavior analyst or technician does not constitute training and is insufficient.

Common areas in which caregivers seek assistance from the behavior analyst include

- Generalization of skills acquired in treatment to home and community settings
- Treatment of maladaptive behaviors that risk the health and safety of the patient or others in home or community settings (e.g., self-injury, elopement, pica, aggressive behaviors); reduction of stereotypic, ritualistic, or perseverative behaviors that impede or interfere with adaptive functioning; development of alternative behaviors that are functional, adaptive, and appropriate
- Training of adaptive skills such as communication, everyday living skills, and skills required to maintain good health (for example, personal hygiene, cooperating with dental and medical procedures, feeding, sleep) in settings where it is critical that they occur
- Developing skills to enhance relationships with family members, such as interacting appropriately with siblings

Authorizations for services to the patient should not be predicated on requirements for parents or other caregivers to participate in training or to implement treatment protocols with the patient for any fixed, pre-determined amount of time. Further, that time must not be counted toward, substituted for, or offset against ABA services delivered directly to the patient by professional behavior analysts, assistant behavior analysts, and behavior technicians.

Coordination with other professionals

Treatment goals are most likely to be achieved when there is shared understanding and coordination among all healthcare providers and professionals. The BACB's *Professional and Ethical Compliance Code for Behavior Analysts* requires behavior analysts to recommend and use treatment procedures that have proved most effective in scientific studies. The behavior analyst must also review and evaluate the likely effects of alternative treatments, including those provided by other disciplines, as well as no treatment. In addition, behavior analysts must consult with or refer patients to professionals from other disciplines when a patient presents with needs that are beyond the training and competence of the behavior analyst, or where coordination of care with such professionals is appropriate. Examples include collaboration between a prescribing physician and behavior analyst to determine the effects of medication on target behaviors, or between a behavior analyst and clinical psychologist on the treatment of anxiety or mood disorders. Consultation with other professionals helps ensure patient progress through efforts to coordinate care and ensure consistency, especially during transition periods and discharge.

Collaboration is also essential for ensuring that professionals from different disciplines use consistent procedures to promote adaptive behaviors and manage maladaptive behaviors across environments and settings. Differences in theoretical orientations or professional styles may sometimes make coordination difficult. If they result in a patient receiving services that dilute or counter the effectiveness of ABA treatment, the differences must be resolved in the best interests of the patient.

Discharge, transition planning, and continuity of care

Criteria for discharge should be specified when services begin and refined throughout the treatment process. Discharge and transition planning should involve family members, other caregivers, and other professionals who serve the patient in development of a written plan that specifies monitoring and followup procedures as appropriate for the patient and their caregivers. The plan should also include clear descriptions of the roles and responsibilities of all providers and caregivers, as well as criteria and target dates for treatment goals that must be achieved prior to the next phase.

Discharge should generally involve a gradual step-down in services. Discharge from a comprehensive ABA treatment program often requires 6 months or longer. For example, a patient might step down from a comprehensive program to a focused treatment or treatments to address a few remaining goals.

Services should be reviewed and evaluated and discharge planning begun when

- The patient has achieved all treatment goals; OR
- The patient no longer meets diagnostic criteria (as measured by appropriate standardized instruments); OR
- The patient does not demonstrate progress towards goals for successive authorization periods; OR
- The family wishes to discontinue services; OR
- The family and provider are unable to reconcile differences regarding treatment planning and delivery.

In reviews addressing the appropriateness or efficacy of services, including reviews pursuant to any internal or external appeal relating to health insurance benefits, the reviewing body should include at least one credentialed professional behavior analyst with experience in designing and overseeing ABA services for similar patients.

Telehealth service delivery

Although in-person delivery of ABA services is the norm, services may also be delivered remotely via telehealth (synchronous or asynchronous audio- and/or video- conferencing, telephone), either entirely or in combination with in-person services. That may be particularly important for patients in rural areas or other locations where there are insufficient numbers of qualified behavior analysts, and when circumstances restrict the delivery of in-person services, such as during outbreaks of infectious diseases or natural disasters. To determine the appropriateness of telehealth services for a particular patient, the behavior analyst should carefully consider the following factors.

1. *Applicable laws and regulations.* In states with behavior analyst licensure laws, it will be necessary to check the laws and accompanying rules or regulations for the state in which the patient resides to determine if the telepractice of ABA is allowed and if so, by whom and under what conditions. Similarly, state insurance regulations and Medicaid policies should be examined for any provisions regarding telehealth.
2. *Research literature.* Although telehealth delivery of ABA services is relatively new, there is a growing body of research on that topic, and such services can be considered evidence-informed at the very least. Behavior analysts should familiarize themselves with the relevant research when considering telehealth services for a patient.
3. *Provider competencies.* The behavior analyst must evaluate whether they and any supervisees (e.g., behavior technicians, students or other trainees) who will be involved in delivering the services for which telehealth delivery is being contemplated have the skills required to implement those services safely and effectively. If not, ethical standards require that the behavior analyst obtain the necessary training and see that their supervisees can implement the patient's telehealth treatment protocols correctly before initiating telehealth services.

4. *Technology requirements and environment.* The behavior analyst should assess whether patients and the individuals who will assist them in participating in telehealth services have access to a secure internet connection and required technology (both hardware and software) in the remote setting. Space for assessment and treatment sessions must be arranged so that the patient and caregivers are within view of any cameras used for remote observation and clinical direction by the behavior analyst or technician. Additional equipment (e.g., tablet mounts) may be required to optimize their view. Ideally, the environmental arrangement should allow the patient to move freely within and across areas within the treatment setting. Careful placement of the camera will facilitate remote observation of sessions with minimal interruption.

5. *Treatment plan.* The behavior analyst should evaluate the patient's treatment plan to determine if it is suitable for telehealth delivery. Consideration must be given to the relative risks and benefits involved in delivering services remotely vs. in person; whether modifications are needed in treatment goals and objectives as well as procedures for implementing each treatment protocol (e.g., types of reinforcers, reinforcer delivery, prompting, materials); and who will implement the telehealth protocols (behavior technicians, other direct care staff, family members or other caregivers). The behavior analyst should also assess whether the remote treatment setting is conducive to safe and effective delivery of services via telehealth. That is especially important if the patient engages in behavior that puts them or others at risk of injury. In such cases, consideration should be given to caregivers' ability to modify the environment by removing objects that may pose risk of injury, or using protective equipment or clothing to ensure safety (e.g., pillows to block aggression, long sleeves to prevent injury due to pinching or biting). That may require providing caregivers with the necessary items as well as training in their use.

6. *Patient characteristics and skills.* The skills required for the patient to participate in telehealth depends on their treatment goals and the nature of the telehealth services. The requisite skills will be different for a patient to whom a behavior analyst or technician will deliver services directly via synchronous, real-time videoconferencing and a patient to whom services will be delivered in person by a caregiver with remote direction from a behavior analyst. For the former, the behavior analyst must assess whether the patient has the skills required to operate the hardware and software and engage with treatment procedures presented on screens and via speakers and microphones, either in real time or via recordings.

7. *Caregiver ability to participate.* If family members or other caregivers will be involved in delivering services via telehealth, the behavior analyst must evaluate the time they can be available, other individuals for whom they may be responsible, and any physical restrictions. A materials inventory may be useful for determining resources that are available in the remote treatment setting so as to minimize the potential for service interruption due to inadequate access to materials. The caregiver's skills in using hardware and software should also be assessed and trained as needed. Similarly, the behavior analyst will need to train the caregiver on skills required to conduct sessions (e.g., preparing materials, technology, and the setting prior to each session; recording notes and charging devices after each session) and to implement all treatment protocols with the patient.

8. *Informed consent.* Prior to implementing telehealth services, the behavior analyst should obtain consent from the patient's parents or guardians and the patient as appropriate. The consent document should provide a clear description of the benefits and risks involved and any other information required to enable patients and caregivers to make fully informed decisions about telehealth services, such as a description of the technology and procedures that will be used, what to expect from the telehealth interactions, and what is known from research. Consent should be sought for each telehealth modality and service provided. For example, a caregiver may consent to the use of video recordings (also known as "store-and-forward" modalities) for clinical consultation, but not to train technicians or others.

Limitations

1. The review of assessments and reports prior to developing or revising a treatment plan must include medical records. If a medical condition is identified that might contribute to a maladaptive behavior or affect the patient's responsiveness to treatment, coordination of care with a qualified medical professional is required.
2. Treatment of maladaptive behaviors that put the patient and/or others at serious risk of injury requires specialized training and expertise, and may need to be provided in specialized programs or facilities.
3. Prior authorization from the payer is required before any services described in the treatment plan are delivered to the patient.
4. Services encompassed by the 0362T and 0373T codes should be preauthorized only when all four of the criteria in the code descriptors are met.
5. Concurrent billing of codes in the adaptive behavior services CPT code family is permissible. Criteria in the descriptors for all codes in concurrent code combination(s) must be met.
6. Services encompassed by codes 97154 and 97158 should be reimbursed only for groups of 2 - 8 patients. For CPT 97157, 2 - 8 sets of family members may be present (e.g., up to 8 sets of parents).
7. Code 97155 services should be reimbursed only if (a) a QHP works directly with the patient to observe changes in behavior or troubleshoot treatment protocols, or (b) the QHP joins the patient and the technician during a treatment session to direct the technician in implementing a new or modified treatment protocol.
8. Code 97156 services should be reimbursed when the QHP provides training to a caregiver who is an adult member of the patient's immediate family unless payer policy includes a broader definition of "caregiver."

Coverage Topics

Adaptive behavior services, applied behavior analysis services

Types of Billing Codes

CPT Category I

CPT Category III

HCPCS

Revenue Codes

Not applicable

CPT/HCPCS Codes

New Category I and revised Category III CPT® codes for adaptive behavior services went into effect January 1, 2019. Those codes replaced all Category III CPT® codes previously used for those services. The use of Category I and revised Category III CPT® Codes to report adaptive behavior services is mandatory.

For reporting to health plans, select the code descriptor that accurately describes the service(s) performed. Do not use a CPT® code that merely approximates the service provided.

97151 Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan

97152 Behavior identification supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes

0362T Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components:

- administered by the physician or other qualified health care 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.

97153 Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes

97154 Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes

97155 Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes

97156 Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes

97157 Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes

97158 Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional face-to-face with multiple patients, each 15 minutes

0373T Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components:

- administered by the physician or other qualified health care 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.

Category I Code Vignettes

97151

A 3-year-old male is brought in by his parents for an assessment. The patient has nonfunctional speech, poor eye contact, repetitive motor movements, tantrums with unexpected changes in routines, and ritualistic play. He does not respond to gestures or his name and has almost no imitative behavior.

97152

A 10-year-old female requires an additional assessment for severe stereotypic behavior that interferes with acquisition of adaptive skills.

97153

A 4-year-old female presents with deficits in language and social skills. She engages in perseverative speech on one or two preferred topics and displays strong emotional outbursts in response to small changes in routines or when preferred items are unavailable.

97154

A 7-year-old female exhibits deficits in social skills. The patient is verbal and has emerging social skills as a result of one-to-one therapy designed to teach basic communication and social interactions. Peer social skills training in a small group is recommended.

97155

A 5-year-old male previously showed steady improvements in language and social skills at home as a result of one-to-one intensive applied behavior analysis intervention, but skill development seems to have reached a plateau recently.

97156

Parents of a 6-year-old male seek training on procedures for helping the child communicate using picture cards (skills he previously developed in ABA therapy sessions with technicians) during typical family routines.

97157

The parents of a 3-year-old male who has pervasive hyperactivity and no functional play, social, or communication skills seek training on how to manage his hyperactive and disruptive behavior and help him develop appropriate play, social, and communication skills.

97158

A 13-year-old female is reported to be isolated from peers due to poor social skills and odd behavior. She has difficulty recognizing emotions in others and often annoys her peers because she tells the same joke over and over and talks incessantly about superheroes.

Category III Code Vignettes

0362T

A 26-year-old male requires additional assessment of a behavior – hitting his head with his fists – that is at risk of becoming self-injurious. Initial direct observation and measurement shows that the behavior occurs more than 50 times per hour on average.

0373T

A 16-year-old male has had two surgeries to relieve esophageal blockages due to pica involving repeated ingestion of small metal objects (e.g., paper clips, push pins). The patient’s pica behavior has not responded to previous treatment.

Modifiers for Consideration

HP, HO, HN, HM, HR, HS, HT, TF, TG, TJ, TS, U5, -22, -25, -52, -59, -93, -95

Medically Unlikely Edits - Per-Patient Per-Day Service Units Guidelines

It is common for commercial health plans to adopt the CMS Medicare Medically Unlikely Edits (MUEs) for CPT codes when structuring their claims processing systems. For the adaptive behavior services CPT code set, however, *Medicaid* MUEs are more clinically appropriate because the typical patient population is not Medicare age or eligible. Medicaid MUEs for the CPT codes listed above can be found by entering the code number in the search box labelled “Find in this Dataset” at <https://data.medicaid.gov/Uncategorized/2020-3Q-NCCI-MUE-Edits-Practitioner-Services/qnva-p5jd>

ICD-10 Codes that Support Medical Necessity

TRUNCATED DIAGNOSIS CODES ARE NOT ACCEPTABLE.

ICD-10-CM code listings may cover a range and include truncated codes. It is the provider’s responsibility to avoid truncated codes by selecting code(s) carried out to the highest level of specificity and selected from the ICD-10-CM book for the year in which the service was performed.

It is not enough to link the procedure code to a correct, payable ICD-10-CM code. The diagnosis or clinical signs/symptoms must be present for the procedure to be paid.

The table below lists ICD-10 codes and descriptors with a crosswalk to the corresponding DSM-5 codes and descriptors for some common conditions for which ABA services may be medically necessary.

ICD-10 Code	ICD-10 Descriptor	DSM-5 Code	DSM-5 Descriptor
F01-F09	Dementia	294.1x; 331.83 (G31.84)	Major and Mild Neurocognitive Disorders
F50.8	Other eating disorders	307.59	Avoidant/restrictive food intake disorder
F63.1	Pyromania	312.33	Pyromania
F63.2	Kleptomania	312.32	Kleptomania
F70-F79	Intellectual disabilities	317-318.2	Intellectual disabilities
F81.0-F81.81	Specific developmental disorders	315.0-315.2	Specific learning disorders
F84.0-F84.9	Pervasive developmental disorders	299.00	Autism spectrum disorder
F88	Global developmental delay or other specified neurodevelopmental disorder	315.8	Global developmental delay

MODEL COVERAGE POLICY FOR ADAPTIVE BEHAVIOR SERVICES

ICD-10 Code	ICD-10 Descriptor	DSM-5 Code	DSM-5 Descriptor
F89	Unspecified disorder of psychological development	315.9	Unspecified neurodevelopmental disorder
F90-F90.9	Attention deficit-hyperactivity disorders	314.00-314.01	Attention deficit-hyperactivity disorders
F91.0-F91.2	Conduct disorders	312.81-312.82	Conduct disorders
F91.3	Oppositional defiant disorder	313.81	Oppositional defiant disorder
F91.8-F91.9	Other or unspecified conduct disorders	312.89	Other specified disruptive, impulse-control, and conduct disorders
F92.8-F92.9	Mixed disorders of conduct and emotions	No DSM-5 equivalent	
F93.0	Separation anxiety disorder of childhood	309.21	Separation anxiety disorder
F94.0	Selective mutism	312.23	Selective mutism
F95.0-F95.9	Tic disorders	307.20-307.23	Tourette and tic disorders
F98.0	Enuresis not due to a substance or known physiological condition	307.6	Enuresis
F98.1	Encopresis not due to a substance or known physiological condition	307.7	Encopresis
F98.21	Rumination disorder of infancy	307.53	Rumination disorder
F98.3	Pica of infancy and childhood	307.52	Pica
F98.4	Stereotyped movement disorders	307.3	Stereotypic movement disorder
G47.00	Insomnia	780.52	Insomnia disorder
I63.9	Cerebral infarction, unspecified (stroke)	290.40 (F01.50); 331.83 (G31.84)	Major or Mild Vascular Neurocognitive Disorder
R41.9	Unspecified symptoms and signs involving cognitive functions and awareness	799.59	Unspecified neurocognitive disorder
R63.3	Feeding difficulties	No DSM-5 equivalent	
S06.0-S06.9	Intracranial Injury	294.11	Major Neurocognitive Disorder Due to Traumatic Brain Injury

All ICD-10-CM codes listed in this table support medical necessity. Use of any ICD-10-CM code not listed here in authorization requests or claims may result in denial.

Acceptable Levels of Competence

Although it is not the carrier's intention or authority to credential providers, a satisfactory level of competence is expected from providers who submit claims for services rendered.

Acceptable levels of competence are as follows:

Qualified healthcare professionals for purposes of billing with this code set are individuals with master's or doctoral degrees who are credentialed to practice ABA independently and to design, oversee, and implement ABA treatment plans. They include Licensed Behavior Analysts (in states with such licensure); Board Certified Behavior Analysts or Board Certified Behavior Analysts-Doctoral credentialed by the Behavior Analyst Certification Board (in states without behavior analyst licensure laws); and some other licensed behavioral health professionals (e.g., psychologists) who have ABA in the legislated scope of practice of their profession and in the scope of their documented individual training and competence.

Board Certified Behavior Analysts or Licensed Behavior Analysts may be assisted by Board Certified Assistant Behavior Analysts or Licensed Assistant Behavior Analysts who have bachelor's degrees and are supervised by Board Certified Behavior Analysts or Licensed Behavior Analysts. Services may be delivered to patients by behavior technicians under the close, ongoing supervision of Licensed Behavior Analysts, Licensed Assistant Behavior Analysts, Board Certified Behavior Analysts, or Board Certified Assistant Behavior Analysts. Behavior technicians have at least a high school education and are (a) nationally certified as a behavior technician or (b) regulated or exempted in state behavior analyst licensure laws.

The largest body of behavior technicians hold the Registered Behavior Technician™ (RBT®) credential from the Behavior Analyst Certification Board. To obtain that credential, applicants must be at least 18 years of age, have at least a high school diploma or equivalent, complete a criminal background check, complete 40 hours of training in ABA, pass a competency-based assessment, and pass a professionally developed written examination in ABA. To maintain the credential, each RBT must work under the close, ongoing supervision of a qualified behavior analyst, comply with an ethics code, and pass an annual competency-based assessment.

The National Uniform Claim Committee's healthcare provider taxonomy codes for and descriptions of providers of ABA services are as follows:

103K00000X Behavior Analyst: A behavior analyst is qualified by at least a master's degree and Behavior Analyst Certification Board certification and/or a state-issued credential (such as a license) to practice behavior analysis independently. Behavior analysts provide the required supervision to assistant behavior analysts and behavior technicians. A behavior analyst delivers services consistent with the dimensions of applied behavior analysis. Common services may include, but are not limited to, conducting behavioral assessments, analyzing data, writing and revising behavior-analytic treatment plans, training others to implement components of treatment plans, and overseeing implementation of treatment plans.

106E00000X Assistant Behavior Analyst: An assistant behavior analyst is qualified by Behavior Analyst Certification Board certification and/or a state-issued license or credential in behavior analysis to practice under the supervision of an appropriately credentialed professional behavior analyst. An assistant behavior analyst delivers services consistent with the dimensions of applied behavior analysis and supervision requirements defined in state laws or regulations and/or national certification standards. Common services may include, but are not limited to, conducting behavioral assessments, analyzing data, writing behavior-analytic treatment plans, training and supervising others in implementation of components of treatment plans, and direct implementation of treatment plans.

106S000X Behavior Technician: The behavior technician is a paraprofessional who practices under the close, ongoing supervision of a behavior analyst or assistant behavior analyst certified by the Behavior Analyst Certification Board and/or credentialed by a state (such as through licensure). The behavior technician is primarily responsible for the implementation of components of behavior-analytic treatment plans developed by the supervisor. That may include collecting data on treatment targets and conducting certain types of behavioral assessments (e.g., stimulus preference assessments). The behavior technician does not design treatment or assessment plans or procedures but provides services as assigned by the supervisor responsible for his or her work.

Documentation Requirements

1. Each claim must be submitted with ICD-10-CM codes that reflect the condition of the patient, and indicate the reason(s) for which the service was performed. Claims submitted without ICD-10-CM codes will be returned.
2. Documentation must be available to the payer upon request

Assessment Code 97151:

The medical record must reflect that (a) the required elements of the code are met; (b) a QHP completed the face-to-face direct and indirect assessments, interpreted the results, and wrote a report and treatment plan; and (c) the assessment was medically necessary.

Assessment Code 97152:

The medical record must reflect that (a) the required elements of the code are met; (b) the technician conducted the follow-up assessment in accordance with one or more protocols developed by the QHP; and (c) the assessment was medically necessary.

Assessment Code 0362T:

The medical record must reflect that (a) all four of the required elements of the code are met; (b) a QHP with expertise in the assessment of destructive behavior provided onsite direction to the technicians who completed the assessment; and (c) the assessment was medically necessary.

Treatment Code 97153:

The medical record must reflect that (a) the required elements of the code are met; (b) the technician delivered the treatment in accordance with one or more protocols developed by the QHP; (c) the QHP provided face-to-face direction and modification of the treatment protocol, as needed, via the 97155 code; and (d) the treatment was medically necessary.

Treatment Code 97154:

The medical record must reflect that (a) the required elements of the code are met; (b) the technician delivered the group treatment in accordance with a protocol developed by the QHP; (c) the QHP provided face-to-face direction and modification of the group treatment, as needed, via the 97155 code; (d) between 2 and 8 patients participated in the group; and (e) the treatment was medically necessary.

Treatment Code 97155:

The medical record must reflect that (a) the required elements of the code are met; (b) the QHP observed a technician implement the treatment protocol and made refinements as indicated, or implemented and systematically varied the treatment in order to refine the protocol; and (c) the treatment was medically necessary.

Treatment Code 97156:

The medical record must reflect that (a) the required elements of the code are met; (b) the QHP provided training to one or more caregivers for a single patient with or without the patient present; and (c) the treatment was medically necessary.

Treatment Code 97157:

The medical record must reflect that (a) the required elements of the code are met; (b) the QHP provided training to multiple caregivers for multiple patients with no patients present; and (c) the treatment was medically necessary.

Treatment Code 97158:

The medical record must reflect that (a) the required elements of the code are met; (b) the QHP provided face-to-face treatment to a group of patients and adjusted the treatment as needed during the session; (c) between two and eight patients participated in the group; and (d) the treatment was medically necessary.

Treatment Code 0373T:

The medical record must reflect that (a) all four of the required elements of the code are met; (b) a QHP with expertise in the treatment of destructive behavior provided onsite direction to the technicians who delivered the services; and (c) the treatment was medically necessary.

General Information

1. The medical record must be made available to the payer upon request.
2. Adaptive behavior services are expected to be delivered according to the current ABA research literature and standards of practice.
3. The documentation must establish medical necessity of the services rendered.
4. Documentation for all codes in the adaptive behavior services code set must include written session notes.
5. When documentation does not establish medical necessity or does not meet the criteria in the code descriptors for the specific services rendered, the payer may deny payment because the services are not reasonable and necessary under Section 1862(a)(1) under the Social Security Act.
6. When providers appeal a denial of payment, they must include all relevant documentation.

Sources of Information and Basis for Decision

This document was prepared as a collaborative effort of the ABA Coding Coalition, its CPT consultant, and a workgroup comprising representatives of providers and health plans. In addition to the research literature listed in the bibliography, principal source materials include

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