

SUPPLEMENTAL GUIDANCE ON INTERPRETING AND APPLYING THE REVISED 2027 CPT CODES FOR ADAPTIVE BEHAVIOR SERVICES

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The ABA Coding Coalition (representatives of the organizations shown above and their consultants) prepared this article to assist providers, billers, and payers in using the modified Category I and elevated Category III CPT codes for adaptive behavior/applied behavior analysis (ABA) services that go into effect January 1, 2027. This document is meant to supplement the essential information about the new codes that is published in the *CPT® 2027 Professional* code book available from the American Medical Association [AMA] storefront on Amazon.

In this article, we provide the descriptor for each code and the typical patient[1] vignette that the AMA CPT® Editorial Panel approved, followed by clinical examples[2] illustrating common uses of that code. Please be aware that the definitions section of the *CPT® 2027 Professional* was expanded to incorporate updates in the definitions of the adaptive behavior codes. Readers should review all definitions carefully. One definitional revision that is essential for providers and health plans to note is that ***the term "protocol modification" has been replaced with "analysis" in the descriptors of all codes that are administered by a physician or other qualified health care professional (QHP).***

The term "**analysis**" in a code descriptor refers to **cognitive work performed by the QHP** during face-to-face delivery of assessment and treatment services (e.g., 97155, 97173, 97156, 97157, 97158) to the patient(s) or caregiver(s) and during non-face-to-face activities (97180) by the QHP. That work involves the QHP observing the patient(s)' or caregiver(s)' responses to assessment or treatment protocols and determining if target behaviors and/or protocols require adjustment. For non-face-to-face code 97180, **"analysis"** is part of the review of data and session notes and clinical decision-making regarding the need

[1] The term "patient" is used throughout to be consistent with the code descriptors.
[2] The clinical examples and frequently asked questions contained in this document are intended to illustrate common applications of the CPT code descriptors and are not intended to establish medical necessity criteria, staffing practices, or treatment or documentation standards nor to replace clinical decision-making. The delivery of adaptive behavior services should be individualized and based on the clinical needs of the patient, applicable CPT guidance, payer policy, and the professional judgment of the qualified health care professional.

to modify or add treatment targets, goals, or protocols. Analysis services require the advanced training and competence of a physician or other QHP and ***may not be administered by a technician***. The QHP's analysis may or may not result in adjustment of treatment protocols, targets, or goals; that is, such adjustments are not required for reporting codes that include analysis services (97180, 97155, 97173, 97156, 97157, and 97158). ***Analysis activities by the QHP must be documented clearly in the corresponding session note(s).***[3]

In this article the revised code set is organized into three categories:

1) assessment codes,
2) non-face-to-face services code, and
3) treatment codes.

Importantly, a new code (97180) has been created for reporting the extensive **non-face-to-face activities** required of a physician or other QHP. Code 97180 is used for patient-specific non-face-to-face activities that do not require the presence of patient(s) or caregiver(s) but are necessary to ensure quality services. Specified activities include QHP review and analysis of data and session notes on patient treatment targets; clinical decision-making regarding the need to modify treatment targets, goals, or protocols and/or making those modifications; clinical decision-making regarding the need for additional assessment and developing or modifying assessment protocols; training technicians to implement patient-specific assessment or treatment protocols; or discharge or transition planning activities.

For codes other than 97151 and 97180, only time spent delivering services face-to-face is reported for billing purposes. Face-to-face, billable time must involve active engagement with the patient(s) or caregiver(s). The mere presence of patient(s) or caregiver(s) during QHP activities does not make those activities billable; all elements of the applicable CPT code descriptor must be met to report a service. Time prior to the patient / caregiver's arrival for a session and after the patient / caregiver's departure should not be counted or reported if it does not involve at least one of the activities enumerated in 97180.

The treatment codes section of this article addresses services provided to patients or caregivers in 1:1 or group formats. Clinical examples are provided for each code and include descriptions of activities that typically occur **prior** to the beginning of each session (i.e., the arrival of the patient[s] or caregiver[s]), **during** the assessment or treatment session, and **after** the session has ended (i.e., after the patient[s] or caregiver[s] depart).

Services Delivered by a QHP

The AMA defines a QHP as "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."[4] Although the adaptive behavior codes may be used by any physician or other qualified health care professional (QHP) with an appropriate license or other credential, the majority of the services will be designed and directed by a behavior analyst (advanced degree professional) or licensed psychologist with competence in behavior analysis and delivered by assistant behavior analysts and/or behavior technicians. Currently, 40 states and the District of Columbia have licensure laws. In other jurisdictions, payers may require that providers be certified by the national Behavior Analyst Certification Board® (BACB®) or another national certifying body.

[3] https://www.casproviders.org/casp-session-note-templates

[4] Page xiv of Introduction of 2027 CPT Professional Edition Codebook

ASSESSMENT CODES

97151

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

TYPICAL PATIENT: A 4-year-old male is brought in by his parents for an assessment. The patient has nonfunctional speech, limited social skills, 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.

CLINICAL EXAMPLES:

Initial assessments

Non-face-to-face services: The QHP reviews the child's medical records, previous assessments, and records of any previous or current treatments.

Prior to the session: Before the face-to-face session, the QHP gathers all necessary information, documents, and materials.

During face-to-face sessions: The QHP conducts an interview with the child's parents / caregivers to solicit their observations of the child's adaptive behaviors (e.g., social, communication, play and leisure, daily living skills, personal safety skills), maladaptive behaviors (e.g., aggression, repetitive patterns of behaviors, elopement, food or liquid refusal, self-injurious behavior), other behaviors that impede safe and healthy functioning, and any other parent / caregiver concerns. During separate sessions, the QHP conducts one or more indirect and/or direct assessments of the child to identify potential adaptive behaviors and skills to be strengthened and maladaptive behaviors to be reduced by treatment.

After each face-to-face session: the QHP puts away materials, cleans up the session space**,** and documents the time spent and activities that occurred during the session in the medical record, consistent with payer policy requirements.

Non-face-to-face services: The data from all assessments (which may include data from behavior identification supporting assessments [97152] or behavior-identification-supporting assessment of harmful behavior [97148, 97149] administered by technicians) are analyzed, discussed with the patient's caregivers and treatment team, and used to develop an individualized treatment plan. The plan specifies goals and objectives, including adaptive behaviors to be developed (e.g., communication, play and leisure, socialization, daily living skills, etc.) and maladaptive behaviors to be reduced (if applicable), all defined in observable, measurable terms. The plan also specifies for each treatment target: (a) the current (baseline) level; (b) procedures for direct observation and measurement; (c) conditions under which the behavior is to occur; (d) a written protocol with instructions for implementing procedures (e.g., materials needed, instructions, prompting and prompt-fading, consequences for correct and incorrect responses, etc.) to change the behavior and promote generalization of behavior changes; and (e) criteria for mastery or attainment of the treatment goal; (f) crisis plan; (g) discharge criteria. The QHP documents the time spent and non-face-to-face activities completed in the medical record, consistent with payer policy requirements

During the final face-to-face service: The QHP discusses assessment findings and recommendations for treatment with the patient and / or caregivers.

Please note: *Assessment activities may be conducted over several days of service; however, each date of service must be individually documented.*

Reassessments

Non-face-to-face services: The QHP reviews and analyzes the data from previous assessments and treatment sessions, reviews the treatment plan and the patient's progress on goals and objectives, and identifies any assessment activities that need to be performed.

Prior to the session: Before the face-to-face session, QHP gathers all necessary information, documents, and materials.

During face-to-face sessions: The QHP conducts one or more indirect and/or direct assessments to identify areas of patient growth as well as any new or continuing areas of need.

After each face-to-face session: The QHP puts away materials, cleans up the session space**,** and documents the time spent and activities that were conducted during the session in the medical record, consistent with payer policy requirements.

Non-face-to-face services: The QHP reviews the assessment results; analyzes treatment targets, goals and objectives, and/or protocols and revises them if necessary; evaluates if a change in the level of services is indicated and if so, provides rationale; prepares a progress report and updated treatment plan; and discusses assessment findings and recommendations with the patient's caregiver(s) and other members of the treatment team. The QHP documents the time spent and indirect (non-face-to-face) activities completed in the medical record, consistent with payer policy requirements.

During the final face-to-face service: The QHP discusses assessment findings and recommendations for treatment with the patient and / or caregivers.

Please note: *Reassessment activities may take place over several days of service; however, each date of service must be individually documented.*

Q: Is 97151 intended to be used for day-to-day evaluation of progress and treatment planning?

A: No. This code is intended for reporting initial assessment / reassessment work. This includes treatment plan development, reporting changes made in response to treatment, and updating treatment plans by the QHP (timeframes for reassessments are determined by payer policy and / or medical necessity). 97151 includes face-to-face time with the patient and / or caregivers to conduct assessments as well as non-face-to-face time to review records, score and interpret assessments, and write or update the treatment plan. The QHP must have conducted both the face-to-face and non-face-to-face activities to report 97151. Day-to-day analysis and other indirect activities are captured by code 97180.

Q: Are all code elements required to be met during each session / date of service (DOS) for 97151 services to be reported?

A: No. The non-face-to-face services encompassed by this code (i.e., QHP scoring of assessments, interpretation of results, preparation of report, and development of a treatment plan may occur on the same day(s) as face-to-face services or on separate days. 97151 assessment and reassessment services

typically take several days to complete, and 97151 should be reported each day those activities (face-to-face and/or non-face-to-face) occur.

****Note: The recommendation to report 97151 on each date of service, rather than at the conclusion of all assessment or reassessment work, is based on the existing MUEs for this code. We recognize the 2018 CPT Assistant article directs the code to be reported once, after all face-to-face and non-face-to-face work concludes, but this is currently not possible because the Medicare MUE of 8 units per day for 97151is less than the number of units typically authorized.****

Q: Can 97151 be reported on the same day as the behavior identification supporting assessment codes (97152, 97148, 97149)**?**

A: Yes. 97151 assessments by the QHP may be conducted on the same day(s) as behavior identification supporting assessments by technicians (97152, 97148, 97149). For example, a patient could undergo a 97151 assessment in the morning and a 97152-supporting assessment in the afternoon, but face-to-face time the QHP spends with the patient for 97151 should not be reported at the same time as the supporting assessment codes administered by technicians. However, 97151 **non-face-to-face** activities by the QHP may occur at the same time as face-to-face supporting assessments by technicians.

Q: Can 97151 and 97180 (non-face-to-face services performed by the QHP) be used interchangeably?

A: No. 97151 and 97180 represent separate and distinct QHP services. 97151 is for face-to-face and non-face-to-face assessment and reassessment activities and writing or revising treatment plans and reports. 97180 is for non-face-to-face services the QHP provides during the course of treatment. 97180 services are limited to the activities specified in the code descriptor, which are focused on the patient's ongoing treatment: review and analysis of data and session notes on patient treatment targets; clinical decision-making regarding the need to modify treatment targets, goals, or protocols and/or making those modifications; clinical decision-making regarding the need for additional assessment and developing or modifying assessment protocols; developing a discharge or transition plan; and training technicians on treatment targets and implementing assessment or treatment protocols.

Q: Can 97151 and 97180 be reported on the same day for the same patient?

A: No. Do not report 97180 and 97151 on the same day for the same patient.

97152

Behavior identification supporting assessment, administered by technician face-to-face with the patient, each 15 minutes

TYPICAL PATIENT A 10-year-old female requires an additional assessment of severe stereotypic behavior that interferes with acquisition of adaptive behaviors. The physician or other QHP has determined from the initial assessment (97151) that the stereotypic behavior is a treatment target and that more information is needed to develop appropriate treatment protocols.

CLINICAL EXAMPLE:

Prior to session: The QHP has determined that a supporting assessment is needed to create treatment goals to address the patient's stereotypic behavior. Prior to the session, the technician gathers all materials required.

During the session (face-to-face): The behavior technician implements the QHP-developed assessment protocols and/or QHP-selected assessment instruments and observes and records occurrences of the patient's stereotypic behavior along with the environmental events that precede and follow those occurrences multiple times in a variety of situations.

After the session: The technician puts away materials, cleans up the session space**,** graphs the resulting data if applicable (indicating on the graph the date, time, and context for each of the data samples), notifies the QHP that the data are available for their review, and documents the time spent and activities that occurred during the session in the medical record, consistent with payer policy requirements.

Q: Does the descriptor for 97152 indicate that technicians can perform assessments independently?

A: No. This code is for reporting supporting assessments conducted by the technician when the QHP determines that they are needed to develop or revise the treatment plan (see code 97151). Supporting assessments may include some components of functional behavior assessment, functional behavior analysis, other structured observations, and/or administration of formal assessment protocols and procedures. The QHP reviews the assessment protocol(s) with the technicians, consistent with relevant laws, ethical standards, and publisher rules, and trains them to implement the protocol(s) correctly without the patient present (97180). The training may occur on the day of a supporting assessment session with the patient or on preceding days. QHP time training the technician without the patient present is reported using code 97180.

Q: What is the difference between 97151 and 97152?

A: There are several differences between these codes. 97151 may only be reported by a QHP, whereas 97152 is reported by a technician. 97151 allows providers to report both face-to-face and non-face-to-face activities by the QHP, while 97152 includes only the time the technician is face-to-face with the patient. 97152 behavior identification supporting assessments are performed at the request of the QHP, and the assessment protocol is crafted by the QHP. 97151 encompasses all assessment activities the QHP uses to evaluate the patient's strengths and needs, identify potential treatment goals, and develop or revise the treatment plan. That may include the results of supporting assessments performed by the technician (97152).

Q: Is time the QHP spends training a technician to conduct a supporting assessment billable?

A: Yes. Prior to the assessment session(s) without the patient present, the QHP reviews the assessment protocol with the technician and trains them to implement the protocol correctly. The training may occur on the day of a supporting assessment session with the patient or on preceding days. QHP time training the technician without the patient present is reported using code 97180.

97148

Behavior identification supporting assessment of harmful behavior, each 15 minutes of technician time face-to-face with a patient, requiring the following components:

- **delivered by two technicians**
- **for a patient who exhibits harmful behavior**
- **conducted in an environment that is customized to the patient's behavior**

TYPICAL PATIENT:

A 16-year-old male requires additional assessment of self-injurious behavior (SIB) that puts him at risk of injury. Initial direct observation and measurement show that the SIB (striking his eyes with his fist)

occurs more than 50 times per hour on average. Two technicians are required to administer the assessment protocol.

CLINICAL EXAMPLE:

Prior to the session: Without the patient present, technicians have been trained to implement the supporting assessment protocols, to arrange a space in the patient's home where the assessment session can be conducted safely, and to note idiosyncratic aspects of the patient's behavior (97180). For the session, technicians gather materials and customize the space in the patient's home where the assessment session will occur to ensure that it is safe for the patient.

During the session (face-to-face): Two technicians work with the patient in a safe environment according to a QHP-designed protocol. One technician carries out the QHP-designed procedures and records continuous real-time data on the patient's SIB. The second technician stands close behind the patient and gently blocks his attempts to strike his eyes with his fist. The QHP is on site and immediately available and interruptible to join the session, if needed. (If the QHP is present, report 97155 for their time separately.)

After the session: The technicians put away materials, clean up the session space**,** graph the resulting data (indicating on the graph the date, time, and context for each of the data samples), notify the QHP that the data are available for their review, and document the time the technicians spent and the activities that occurred during the session in the medical record, consistent with payer policy requirements.

+97149

additional technicians present, each 15 minutes (list separately in addition to code for primary procedure)

TYPICAL PATIENT:

A 16-year-old male exhibits self-injurious behavior (SIB)) that puts him at risk of injury. Initial direct observation and measurement show that the SIB (striking his eyes with his fist) occurs more than 50 times per hour on average. Additional assessment (which may include a functional behavior analysis to identify environmental events that influence the SIB) is necessary to develop procedures for treating that harmful behavior. The QHP has determined that three technicians are required to ensure the patient's safety during assessment sessions.

CLINICAL EXAMPLE:

Prior to the session: Without the patient present, technicians have been trained to implement the supporting assessment protocols, to arrange a space in the patient's home where the assessment session can be conducted safely, and to note idiosyncratic aspects of the patient's behavior (97180). For the session, technicians gather materials and customize the space in the patient's home where the assessment session will occur to ensure that it is safe for the patient.

During the session (face-to-face): The technicians work with the patient according to a QHP-designed assessment protocol. Two technicians carry out the procedures and record continuous real-time data on the patient's SIB. The third technician stands close behind the patient and gently blocks his attempts to strike his eyes with his fist. The QHP is on site and immediately available and interruptible to join the session, if needed. (If the QHP is present, report 97155 for their time separately.)

After the session: The technicians put away materials, clean up the session space**,** graph the resulting data, and document the time the technicians spent and the activities that occurred during the session in the medical record, consistent with payer policy requirements.

Q: What is meant by "harmful behavior?"

A: Harmful behavior is defined as any behavior that jeopardizes the patient's health or safety or poses a risk of harm or medical consequences for the patient or others. Examples include but are not limited to self-injurious behavior, aggression, property destruction, pica, elopement, feeding difficulties, sleep difficulties, rumination, bruxism, mouthing objects, inadequate fluid intake, skin picking, resistance to or lack of cooperation with dental and medical care procedures, and other behaviors that may necessitate medical treatment.

Q: What is meant by a "customized environment?"

A: For codes 97148, 97149, 97159, and 97160, the term "customized" means that the environment is configured to conduct a supporting assessment (97148, 97149) or treatment (97159, 97160) of harmful behavior safely, given the characteristics of the specific behavior. For some patients that can be accomplished in the home. For example, if a patient displays aggression using objects, objects that the patient might use as dangerous weapons (e.g., a wooden baseball bat) would be removed and replaced with safer items (e.g., a foam baseball bat). Other patients may require treatment in a padded treatment room. For example, a patient who engages in severe head banging may require functional analysis and initial treatment in a padded treatment room because the behavior causes tissue damage and places the patient at risk for detached retinas.

Q: Is a QHP required to be "on site" during the delivery of harmful behavior assessment services and, if so, can that requirement be met by telehealth?

A: Yes. The QHP is required to be on site and immediately available to join the session during the delivery of all harmful behavior assessment and treatment services (97148, 97149, 97159, 97160). Where clinically appropriate, that requirement may be met by telehealth, i.e., the QHP participating in the session remotely. Even if the QHP deems remote delivery clinically appropriate, payer policies, laws, and regulations vary, so providers must check the policies of each payer and the laws and regulations in each jurisdiction in which they provide services to determine whether telehealth is allowed.

Q: Can 97148, 97149, and 97155 be billed concurrently?

A: Yes. If the QHP is physically present during a 97148 or 97149 session, the QHP's face-to-face time directing the technicians in the implementation of harmful behavior assessment protocols should be reported with 97155.

Q: Can 97148 be reported when additional technicians are needed for safety during a scheduled 97151 or 97152 (1:1) assessment on an impromptu basis, e.g., if harmful behavior occurs unexpectedly and a second technician steps in to help?

A: No. Unless all the elements of code 97148 are met, additional technicians would not be billable. In that scenario, it is unlikely that all elements of 97148 would be present because the session was scheduled as a 97151 (QHP and patient) or 97152 (technician and patient) assessment service. The customized environment element of 97148 is unlikely to be present for such sessions; therefore, it would not be appropriate to report 97148.

Q: Can 97148 and 97149 be reported when additional technicians are needed for safety on an impromptu basis, e.g., if harmful behavior occurs unexpectedly and a third technician steps in to help?

A: Yes. If all 97148 elements are present and all payer requirements are met (such as prior authorization), adding a third, fourth, or fifth technician (97149) on an impromptu basis may be appropriate. The need for additional technicians to maintain safety may arise unexpectedly during a session when harmful behavior occurs. Providers must ensure that the number of technicians needed is medically necessary and the service is delivered according to a QHP-designed protocol that identifies the clinical circumstances under which one or more additional technicians may be needed to safely implement the protocol, based on the patient's clinical presentation and identified risk. Codes 97148 and 97149 should not be reported solely because an additional technician happened to assist during a session. Documentation should support the medical necessity for multiple technicians and the services provided by each technician.

Q: Is time the QHP spends training technicians to deliver harmful behavior supporting assessment services billable?

A: Yes. Supporting assessments may include some components of functional behavior assessment, functional behavior analysis, other structured observations, and/or administration of formal assessment protocols and procedures. The QHP reviews the assessment protocol(s) with the technicians, consistent with relevant laws, ethical standards, and publisher rules, and trains them to implement the protocol(s) correctly without the patient present (97180). The training may occur on the day of a supporting assessment session with the patient or on preceding days.

Q: Can an additional technician be used for patients who do not display self-injurious behavior, aggression, or property destruction?

A: Yes. For example, an additional technician may be required for a patient with a history of choking due to stuffing food into their mouth rapidly during meals. During mealtime, the additional technician would gently block attempts to stuff food while other technicians implement an assessment protocol to determine the function(s) of the patient’s rapid eating (97148).

Similarly, an additional technician may be required for a patient with a history of elopement (e.g., running into busy streets). During assessment sessions, the additional technician would position themselves near the patient and the exit to help prevent or minimize harm associated with elopement while allowing the assessment to proceed safely as other technicians implement the assessment protocol to determine the function(s) of the patient's elopement behavior (97148).

Q: The code descriptor says, “additional technicians.” How many additional technicians are allowed?

A: 97149 is an add-on code to 97148, meaning that 97149 may not be reported alone. 97148 requires two technicians. 97149 allows the addition of up to three more technicians to a maximum total of five technicians.

Q: How does the rounding rule apply to 97149 if additional technicians are not present for the same amount of time?

A: If all additional technicians are not present for the same amount of time, sum up the time spent by all technicians and apply the rounding rule to that total time.

> **Example of a behavior identification supporting assessment (functional analysis) session for a patient with a harmful feeding disorder:**

Most of the functional analysis protocol conditions developed by the QHP can be implemented safely by two technicians. However, one assessment condition involves direct presentation of food and temporary interrupting of rapid eating, which increases the likelihood of aggressive or self-injurious behavior. During this condition of the protocol, technician 1 implements the assessment protocol (e.g., food presentation and reinforcer delivery), technician 2 records data on the patient's responses to the food presentations, and technician 3 provides safety support by maintaining safe positioning and blocking any attempts at aggressive or self-injurious behavior, so that the assessment protocol can be implemented safely and effectively

- **2:30 -3:15 pm** - Two technicians begin implementing the assessment protocol. Report 3 units of 97148 for 45 minutes.
- **3:15 - 3:58 pm** - One additional technician joins the session to manage safe positioning of the patient and block attempts at aggressive or self-injurious behavior, for a total of three technicians. Report 3 units of 97148 for 43 minutes and 3 units of 97149 for 43 minutes.
- **3:58 - 4:30 pm** – The third technician leaves and two technicians continue implementing the assessment protocol. Report 2 units of 97148 for 32 minutes.

TOTAL UNITS FOR THIS DATE OF SERVICE:

- 97148 = 8 units for technicians 1 and 2
- 97149 = 3 units for technician 3

NON-FACE-TO-FACE SERVICES CODE

97180

Adaptive behavior non-face-to-face services, personally performed by a physician or other QHP, each 15 minutes, with any of the following elements, when performed:

- **review and analysis of data and session notes on patient treatment targets,**
- **clinical decision making regarding the need to modify treatment targets, goals, or protocols and/or making those modifications,**
- **clinical decision making regarding the need for additional assessment and developing or modifying assessment protocols,**
- **developing discharge or transition plan,**
- **training on or reviewing treatment targets and/or revised assessment or treatment protocols with technician(s).**

TYPICAL PATIENT: A 4-year-old female has limited language and social skills. She engages in perseverative speech on one or two preferred topics and exhibits disruptive behaviors (high-intensity vocalizations, throwing objects) in response to small changes in routines or when preferred items are unavailable. Additional assessment, data analysis, and development or adjustment of treatment protocols by the physician or other QHP outside of face-to-face treatment sessions is required.

CLINICAL EXAMPLE:

Prior to the non-face-to-face service: The QHP accesses relevant treatment notes, data, and other clinical information from QHP- and/or technician-delivered treatment.

During the non-face-to-face service: The QHP reviews and analyzes treatment data and documentation relevant to the patient's treatment targets, goals, protocols, or other clinical considerations under review. Based on this analysis, the QHP engages in clinical decision-making regarding whether there is a need to adjust any treatment targets and/or protocols. The QHP determines that the data indicates that the current protocol for addressing disruptive behaviors in the home needs to be adjusted and develops a revised protocol for the technician to implement in the home. The QHP revises the protocol to reflect the change and trains the technician to implement the revised treatment protocol correctly without the patient present. For treatment targets, goals, and protocols that are reviewed and determined to remain clinically appropriate, the QHP documents the clinical decision not to adjust. Each time the QHP engages in non-face-to-face 97180 activities for the patient, they document the date, the time spent, and the activities that occurred**.** At the end of each 7-day period (e.g., Sunday through Saturday), all 97180 times for the patient are summed, and the total units are reported to the health plan on one claim.

Note: *Per CPT® guidance, qualifying non-face-to-face activities may be aggregated and reported for a 7-day reporting period (e.g., Sunday through Saturday) provided that each date of service within the 7-day period is documented individually. The AMA rounding rule should be applied to each date of service separately, before the units for the week are summed and billed on a single claim line, see the example below.*

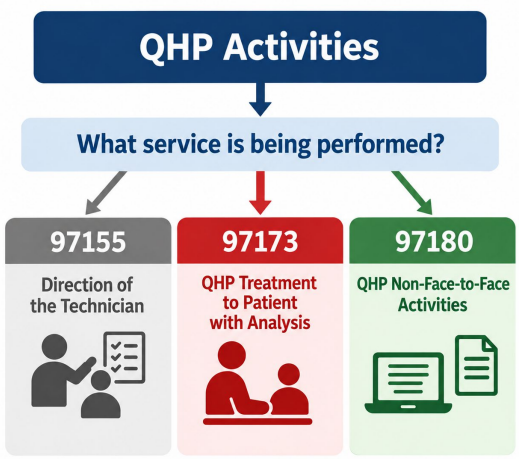


Q: Is there a set amount of time or percentage of time a patient receives direct services that the QHP should perform 97180 services?

A: No. As with all adaptive behavior codes, authorization of 97180 should be based on medical necessity for the individual patient. Prior authorization requests should be individualized to each patient's treatment and service needs; there is no prescribed formula. CASP Guidelines describe an average of 1–2 hours of QHP activity (e.g., 97155, 97173, 97180) for every 10 hours of technician-delivered treatment (97153),

emphasizing individualized treatment decisions – this guidance is not intended to prescribe utilization of any single QHP activity or CPT® code.

For 2027 planning, consider how activities that are currently reported under 97155 align with the revised 97155 descriptor versus other applicable codes, such as new code 97173. 97180 provides for specified non-face-to-face QHP activities that were not previously separately reportable. In 2027, 97155 is no longer a dual-use code and is limited to direction of the technician; 97173 describes QHP-delivered adaptive behavior treatment with analysis directly with the patient.



Q: When SHOULD a QHP report this service?

A: Report 97180 when the QHP engages in any of the following activities:

- review and analysis of data and session notes on patient treatment targets,
- clinical decision-making regarding the need to modify treatment targets, goals, or protocols and/or making those modifications,
- clinical decision-making regarding the need for additional assessment and developing or modifying assessment protocols,
- developing discharge or transition plan,
- training on or reviewing treatment targets and/or revised assessment or treatment protocols with technician(s).

Q: Is training on an existing treatment or assessment protocol billable under 97180?

A: Yes, training that is specific to the benefit of the patient and their treatment plan may include training on new, or retraining on existing, treatment targets, goals, or protocols

Q: Is training under 97180 limited to newly hired technicians?

A: No. 97180 is not limited to newly hired technicians. Any patient-specific training of technicians in the absence of the patient(s) is a billable activity under 97180.

Q: Can this code be used to report the QHP's time writing session notes or engaging in any other non-face-to-face activities, other than those activities delineated in the code descriptor?

A: No. 97180 is limited to the non-face-to-face activities delineated in the code descriptor, which do not include time spent writing session notes.

Q: Can this code be billed for internal quality assurance activities?

A: No. 97180 services are provided for the benefit of the patient or their caregivers. This code should not be used for reviewing notes or other documents for audit or compliance purposes. However, time the QHP spends reviewing and analyzing session notes and data for the purpose of clinical decision-making should be included in the total time billed for this code for each 7-day period.

Q: What constitutes a discharge or transition plan?

A: A discharge or transition plan is developed when the QHP's review of the patient's response to treatment and clinical decision-making indicates that discharge or transition from current services will benefit the patient or their caregivers. The discharge or transition plan should document the patient's current status and any recommendations for maintaining that status after current treatment concludes. Transition and discharge plans that are drafted when the patient enters treatment should be reviewed and revised as treatment evolves. 97180 should not be used to report administrative discharge or transition activities by the QHP, such as preparing payer notices, transferring data or records, drafting a letter to another service provider, or sending an email to a patient's parents or legal guardians.

Q: Can 97180 be used for non-patient-specific training required by payers or provider agencies?

A: No. One of the activities for which 97180 can be used is the QHP's training of technicians to deliver medically necessary services to patients without a patient present. That training must be specific to and for the benefit of the patient. It should focus on training and re-training technicians to implement existing and new or modified assessment and treatment protocols to address targets and goals that are part of the patient's adaptive behavior treatment plan. 97180 should not be used for other general training of technicians (e.g., on the principles of behavior analysis, CPR or other safety procedures, or agency employee policies and procedures).

Q: When 97180 is reported for training technician(s) on treatment targets and/or revised assessment or treatment protocols, is the technician time separately reported?

A: No. 97180 is a service delivered by the QHP. In cases where the QHP is training a technician or multiple technicians on treatment targets and/or revised assessment or treatment protocols related to a specific patient, only the QHPs time is billed. The technician's time is not separately reported or billable.

Q: I know that non-face-to-face services can be provided by a QHP on the same, or separate, days as face-to-face treatment, but if NFTF activities occur on a day that FTF treatment does not, does a patient's cost share apply to those NFTF services?

A: This depends on the patient's health benefit plan. The activities listed in the code descriptor for 97180 are separate reportable non-face-to-face services performed by a QHP and are distinct from those captured in all other codes in the ABA code set. Because it is separately reported, applicable cost sharing (e.g. deductibles, co-pays, co-insurance, and out of pocket maximums) may apply in accordance with the patient's health benefit plan and applicable requirements. The fact that the 97180 service is provided without the patient present, or on a day when no face-to-face service occurs, does not determine whether cost sharing applies. Note: Per CPT® guidance, qualifying non-face-to-face activities may be aggregated and reported for a 7-day reporting period (e.g., Sunday to Saturday) provided that each date of service within the 7-day period is documented individually. This means that all units of 97180 services during the

7-day period are reported together on one claim line and patient cost-share will be applied to one date of service, as opposed to each date of service during the 7-day period the 97180 services occurred.

Example:
A QHP conducts 97180 services during a 7-day period for one patient as follows:

- **Monday** – 30 minutes in the morning and 30 minutes in the late afternoon reviewing the prior week's data and session notes documented by the patient's technicians. The QHP documents each 97180 session (morning and afternoon) in the electronic medical record (EMR).
- **Wednesday** – 2 hours updating treatment targets in the patient's EMR portal and mapping those changes over to the patient's treatment plan. The QHP documents the 97180 session in the EMR.
- **Thursday** – 1 hour training the technicians on the updated treatment targets they added to the patient's program the day prior. The QHP documents the 97180 session in the EMR.
- **Friday** – 1 hour reviewing the remaining data and session notes for the week (TH/F sessions) documented by patient's technicians. The QHP documents the 97180 session in the EMR.

TOTAL: 5 hours of 97180 services for one patient, billed on Friday for a total of 5 hours = 20 units of 97180. The QHP documents the 97180 session in the EMR.

Any cost share or patient responsibility the patient has under their health plan will apply to the 20 units billed on Friday for all 97180 services rendered in this 7-day period (e.g., Sunday through Saturday).

Q: Can this code be used for coordinating care with other QHPs?

A: No. There may be other CPT codes available for providers to report coordination of care; however, care coordination activities are not included in the adaptive behavior code set and require other reporting mechanisms when covered by payer policy. Providers should review payer contracts and policies to determine if the use of coordination-of-care CPT codes is allowed.

Table 1. QHP activities that are and are not reportable with 97180

QHP Activity	Reportable	Not Reportable
Writing session notes		X
Reading journal articles or other published sources		X
Setting up a treatment space or gathering materials prior to a session		X
Training technicians on general adaptive behavior concepts or payer or employee policies and procedures that do not address medically necessary treatment for a specific patient (e.g., general safety procedures, human resources requirements)		X
Meeting with other service providers (e.g., daycare staff, day program staff)		X
Care coordination activities involving providers of other health care services (e.g., physicians, speech-language pathologists, occupational therapists, physical therapists, counselors)		X
Training technician(s) to implement assessment protocols with a patient or caregiver	X	

QHP Activity	Reportable	Not Reportable
Training technician(s) to implement treatment protocol(s) with a patient or caregiver	X	
Reviewing and analyzing data and session notes on patient treatment targets	X	
Clinical decision-making regarding the need to modify treatment targets, goals, or protocols and/or making those modifications	X	
Clinical decision-making regarding the need for additional assessment and developing or modifying assessment protocols	X	
Developing discharge or transition plan	X	

TREATMENT CODES

97153

Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient, each 15 minutes

TYPICAL PATIENT: 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 exhibits disruptive behaviors (high-intensity vocalizations, throwing objects) in response to small changes in routines or when preferred items are unavailable.

CLINICAL EXAMPLE:

Prior to the session: The technician reviews the data and session notes from the most recent treatment sessions and gathers all materials required for that session.

During the session (face-to-face): The technician implements the QHP-developed adaptive behavior treatment protocols and data collection procedures with the patient in the setting designated in the treatment plan. Sessions are designed to provide planned opportunities for the patient to practice identified target behaviors in the treatment plan consistent with the goals of treatment.

After the session: The technician puts away materials, cleans up the session space, and documents the time spent and the activities that occurred during the session and any aspects of the treatment protocols that may need to be analyzed by the QHP in the medical record, consistent with payer policy requirements.

Q: What is an adaptive behavior treatment protocol?

A: An adaptive behavior treatment protocol encompasses (a) a written description of procedures for implementing a specified service to address a patient's assessment or treatment goal(s) and (b) implementation of the procedures with the patient.

Q: Can I report 97153 and 97155 concurrently?

A: Yes, 97153 and 97155 may be reported concurrently if the criteria in the descriptors of both codes are met. A single QHP may not report 97153 and 97155 concurrently. See the *Concurrent Billing Overview* table in the *Other Frequently Asked Questions* section of this article. Please note, code 97155 will ALWAYS be reported with another technician-delivered CPT code and will not be reported on its own under the 2027 code set.

Q: Is the QHP's time reviewing treatment protocols and data after a 97153-session billable?

A: Yes. Time the QHP spends reviewing and analyzing session notes and data recorded by the patient's treatment team for the purpose of clinical decision-making can be reported per 7-day period separately using 97180.

97154

Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients, each 15 minutes

TYPICAL PATIENT: A 7-year-old female exhibits deficits in social skills, specifically interacting with other children. The patient has age-appropriate verbal communication skills and emerging social skills as a result of previous one-to-one interventions. The QHP has developed a treatment protocol to develop her skill in initiating interactions with other children in the context of a small group of peers.

CLINICAL EXAMPLE:

Prior to the session: The technician reviews the data and session notes from the most recent treatment sessions and gathers all materials required for that session.

During the session (face-to-face): The technician implements the QHP-developed treatment and data collection protocols in small-group activities. Sessions are designed to provide planned opportunities for each patient to practice individualized target behaviors consistent with the goals of treatment.

After the session: The technician puts away materials, cleans up the session space, and documents the time spent and the activities that occurred during the session and any aspects of the treatment protocols that may need to be analyzed by the QHP in the medical record, consistent with payer policy requirements.

Q: What is an adaptive behavior treatment protocol?

A: An adaptive behavior treatment protocol encompasses (a) a written description of procedures for implementing a specified service to address a patient's assessment or treatment goal(s) and (b) implementation of the procedures with the patient.

Q: What constitutes a group?

A: A group includes at least 2 patients. The prior group size maximum of 8 patients has been removed in the 2027 code set. The maximum group size is determined by the QHP based on the treatment needs of the patients in the group. The revised coding guidance does not set a group size limit. Any payer-specific administrative requirements are separate from CPT guidance.

Q: Do I report 97154 for each patient in the group session?

A: Yes. Report this code for each patient attending the group session. For example, if five patients attend a group session from 9 am to 10 am, report 97154 for each patient in attendance (4 units per patient). Documentation should reflect the individualized treatment plan goals addressed with each patient during the group session.

Q: Does the QHP have to be present for the technician to bill 97154?

A: No. 97154 requires that the technician implement QHP-developed adaptive behavior service protocols in a group setting.

Q: Can I report 97154 and 97155 concurrently?

A: Yes. 97154 and 97155 may be reported concurrently as long as the criteria in the descriptors for both codes are met.

Q: Can I report 97154 and 97158 concurrently?

A: No. 97158 is intended to be reported for QHP-led group sessions only. QHP direction of the technician's implementation of treatment rendered to patients in a group should be reported using 97155 concurrently with 97154.

Q: How should the QHP's time directing a single technician delivering 97154 with multiple patients be calculated?

A: 97154 is reported for all patients in the group as noted above. When a QHP joins a technician-led group session for the purpose of directing the technician on their implementation of treatment protocols with the patients in the group, the QHP's time should be reported with 97155. However, 97155 should only be reported for a group attendee based on the time and attention the QHP spends related to that individual patient. For example, if the QHP joins a technician-led session for a group of five patients for one hour and only directs the technician on their implementation of protocols with two patients, 97155 is reported only for those two patients, reflecting the time the QHP spent on each respective patient's treatment.

97159

Adaptive behavior treatment of harmful behavior, each 15 minutes of technician time with a patient, requiring the following components:

- **delivered by two technicians,**
- **for a patient who exhibits harmful behavior,**
- **conducted in an environment that is customized to the patient's behavior**

TYPICAL PATIENT:

A 16-year-old male requires treatment for self-injurious behavior (SIB) – hitting his eyes with his fist. Two technicians are needed to administer the treatment protocol.

CLINICAL EXAMPLE:

Prior to the session: Without the patient present, technicians have been trained to implement the treatment protocol and to arrange the environment so that treatment sessions can be conducted safely. For the session, technicians review the data from the most recent treatment sessions, gather materials, and customize the space where the treatment session will occur to ensure that it is safe for the patient.

During the session (face-to-face): Two technicians work with the patient in a safe environment according to a QHP-designed protocol. One technician carries out the QHP-designed procedures and records continuous real-time data on the patient's SIB. The second technician stands close behind the patient and gently blocks his attempts to strike his eyes with his fist. The QHP is on site and immediately available and interruptible to join the session if needed. (If the QHP is present, report 97155 for their time separately.)

After the session: The technicians put away materials, clean up the session space**,** graph the resulting data (indicating on the graph the date, time, and context for each of the data samples), notify the QHP that the data are available for their review, and document the time the technicians spent and the activities that occurred during the session in the medical record, consistent with payer policy requirements.

+97160

each additional technician present, each 15 minutes (List separately in addition to code for primary procedure)

TYPICAL PATIENT: A 16-year-old male requires treatment for self-injurious behavior (SIB) – hitting his eyes with his fist. The QHP has determined that three technicians are required to administer the treatment protocol and ensure the patient's safety during treatment sessions.

CLINICAL EXAMPLE:

Prior to the session: Without the patient present, technicians have been trained to implement the treatment protocol and to arrange the environment so that treatment sessions can be conducted safely. For the session, technicians review the data from the most recent treatment sessions, gather materials, and customize the space where the treatment session will occur to ensure that it is safe for the patient.

During the session (face-to-face): The technicians work with the patient according to a QHP-designed treatment protocol. Two technicians carry out the procedures and record continuous real-time data on the patient's SIB. The third technician stands close behind the patient and gently blocks his attempts to strike his eyes with his fist. The QHP is on site and immediately available and interruptible to join the session if needed. (If the QHP is present, report 97155 for their time separately.)

After the session: The technicians put away materials, clean up the session space**,** graph the resulting data (indicating on the graph the date, time, and context for each of the data samples), notify the QHP that the data are available for their review, and document the time the technicians spent and the activities that occurred during the session in the medical record, consistent with payer policy requirements.

Q: For 97159, is each technician's time reported separately?

A: No. Report only the total session time during which the two technicians implement the procedure with the patient. For example, if the two technicians conduct a 1-hour session, report 4 units of 97159 (15 minutes x 4 units = 60 minutes or 1 hour). This code represents the work of two technicians, so do not count or report their time separately.

Q: Can 97159, 97160, and 97155 be billed concurrently?

A: Yes. If the QHP is physically present during a 97159 or 97160 session, the time they spend face-to-face directing the technicians in implementing treatment protocols and analyzing how the protocols are functioning should be reported using 97155.

Q: What is meant by "harmful behavior?"

A: Harmful behavior is defined as any behavior that jeopardizes the patient's health or safety or poses a risk of harm or medical consequences for the patient or others. Examples include but are not limited to self-injurious behavior, aggression, property destruction, pica, elopement, feeding difficulties, sleep difficulties, rumination, bruxism, mouthing objects, inadequate fluid intake, skin picking, resistance to or lack of cooperation with dental and medical care procedures, and other behaviors that may necessitate medical treatment.

Q: What is meant by a "customized environment?"

A: For codes 97148, 97149, 97159, and 97160, the term "customized" means that the environment is configured to conduct a supporting assessment (97148, 97149) or treatment (97159, 97160) of harmful behavior safely, given the characteristics of the specific behavior. For some patients that can be accomplished in the home. For example, if a patient displays aggression using objects, objects that the patient might use as dangerous weapons (e.g., a wooden baseball bat) would be removed and replaced with safer items (e.g., a foam baseball bat). Other patients may require treatment in a padded treatment room. For example, a patient who engages in severe head banging may require functional analysis and initial treatment in a padded treatment room because the behavior causes tissue damage and places the patient at risk for detached retinas.

Q: Is a QHP required to be "on-site" during the delivery of harmful behavior treatment services and if so, can that requirement be met by telehealth?

A: The QHP is required to be on site and immediately available to join the session during the delivery of all harmful behavior assessment and treatment services (97148, 97149, 97159, 97160). Where medically necessary and clinically appropriate, that requirement may be met by telehealth, i.e., the QHP participating in the session remotely. Even if the QHP deems remote delivery clinically appropriate, payer policies, laws, and regulations vary, so providers must check the policies of each payer and the laws and regulations in each jurisdiction in which they provide services to determine whether telehealth is allowed.

Q: Can 97159 be reported when additional technicians are needed for safety during a scheduled 97153 (1:1) session on an impromptu basis, e.g., if harmful behavior occurs unexpectedly and a second technician steps in to help?

A: No. Unless all the elements of code 97159 are met, it is not reportable. In this scenario it is unlikely that all elements of
97159 would be present because the session was scheduled as a 97153 (technician and patient) treatment session. The customized environment element of 97159 is unlikely to be present for such sessions. Therefore, it would not be appropriate to report 97159.

Q: Can 97159 and 97160 be reported when additional technicians are needed for safety but on an impromptu basis, e.g., if harmful behavior occurs unexpectedly and a third technician steps in to help?

A: Yes. If all 97159 elements are present and all payer requirements are met (such as prior authorization), adding a third, fourth, or fifth technician (97160) on an impromptu basis may be appropriate. The need for additional technicians to maintain safety may arise unexpectedly during a session when harmful behavior occurs. Providers must ensure that the number of technicians needed is medically necessary and the service is delivered according to a QHP-designed protocol that identifies the clinical circumstances under which one or more additional technicians may be needed to safely implement the protocol, based on the patient's clinical presentation and identified risk. Codes 97159 and 97160 should not be reported solely because an additional technician happened to assist during a session. Documentation should support the medical necessity for multiple technicians and the services provided by each technician.

Q: Is time the QHP spends training technicians to implement harmful behavior treatment protocols billable?

A: Yes. The QHP reviews the treatment protocol(s) with the technicians and trains them to implement the protocol(s) correctly without the patient present (97180). The training may occur on the day of a 97159 or 97160 treatment session with the patient or on preceding days.

Q: Can an additional technician be used for patients who do not display self-injurious behavior, aggression, or property destruction?

A: Yes. For example, an additional technician may be required for a patient with a history of choking due to stuffing food into their mouth rapidly during meals. During mealtime, the additional technician would gently block attempts to stuff food while other technicians implement a treatment protocol to reduce the patient’s rapid eating (97159).

Similarly, an additional technician may be required for a patient with a history of elopement (e.g., running into busy streets). During treatment sessions, the additional technician would position themselves between the patient and a doorway that opens onto a street to prevent or minimize harm from elopement while the other technicians implement a treatment protocol to reduce the patient’s elopement behavior (97160).

Q: The code descriptor says, “additional technicians.” How many additional technicians are allowed?

A: 97160 is an add-on code to 97159, meaning that 97160 may not be reported alone. 97159 requires two technicians and 97160 allows for the addition of up to three more technicians, for a maximum total of five technicians.

Q: How does the rounding rule apply to 97160 if additional technicians are not present for the same amount of time?

A: If all additional technicians are not present for the same amount of time, sum the time spent by all technicians and apply the rounding rule to that total time.

> **Example of a harmful behavior treatment session in which certain components of the treatment protocol require more technicians than others for the typical patient described previously:**
>
> A 3-hour session is conducted with two behavior technicians for much of the session. Due to the patient's history of SIB (hitting his eyes with his fist), treatment delivered in outdoor community-based settings requires one additional technician to ensure safe implementation of treatment

protocols and effective responses to attempted instances of SIB and to maintain patient and public safety.

- **1:00 – 2:15 pm** – Treatment is conducted in a clinic treatment room with two technicians implementing treatment protocols and recording data. Report 5 units of 97159 for 75 minutes.

- **2:15 – 2:57 pm** – Treatment transitions to outdoor community-based settings. A third technician joins the session due to increased risks to the patient's safety associated with SIB occurrences in environments that are less easily managed than the clinic. Two technicians implement treatment procedures while the additional technician monitors the patient's safety and assists with implementing the procedures as needed. Report 3 units of 97159 for 42 minutes and 3 units of 97160 for 42 minutes to capture the time of the additional technician.

- *Note: If two additional technicians are required in the outdoor settings, the 97160 report is doubled to 6 units to capture the time of each additional technician.*

- **2:57 – 4:00 pm** – Treatment transitions back to the clinic treatment room where two technicians continue implementing the treatment protocol. Report 4 units of 97159 for 63 minutes.

In this example, 97160 is reported only for the period during which the third technician is medically necessary to implement treatment protocols safely and manage the increased risk associated with outdoor community-based settings.

97155

Adaptive behavior direction of technician with analysis by a physician or other qualified health care professional, face-to-face with a patient, each 15 minutes

TYPICAL PATIENT:

A 5-year-old male previously showed steady improvements in language and social skills at home as a result of one-to-one treatment, but recently, skill development seems to have reached a plateau. It is necessary for the physician or other QHP to direct the technician to implement the treatment protocols that the QHP has designed to build the patient's language and social skills into daily routines (eg, play, dressing, mealtimes.

CLINICAL EXAMPLE:

Prior to the session: The QHP reviews the patient's schedule to identify the next opportunity to join the technician and the patient in a 97153-treatment session conducted in the context of the patient's play routines. The QHP prepares for the session by gathering needed materials and reviewing the treatment protocol and the procedures the QHP will use to direct the technician to implement the protocol correctly during the session.

During the session (face-to-face): The QHP demonstrates treatment procedures for the technician by working directly with the patient while the technician observes. The technician then implements the treatment protocol with the patient while the QHP observes, provides feedback, records data on the technician's implementation of the treatment procedures, and analyzes the potential need to adjust the treatment target, goal, and/or protocol.

After the session: The QHP records the time they spent face-to-face with the patient and technician, summarizes what occurred during the session, and notes any adjustments needed to treatment protocols, targets, or goals in the medical record consistent with payer policy requirements. If existing treatment protocols are functioning effectively and require no adjustment, that should be documented in the medical record as well.

Note: *Non-face-to-face time reviewing and analyzing data and session notes and/or making clinical decisions regarding the need to adjust treatment targets, goals or protocols after the session is reported with 97180.*

Q: What is "analysis" as that term is used in this code descriptor?

A: Analysis is defined as the cognitive work done by the QHP during face-to-face delivery of treatment services to the patient(s). It involves the QHP observing the patient(s)' responses to treatment protocols and determining if target behaviors and/or protocols need to be adjusted. This service requires the advanced training and competence of a QHP and may not be administered by a technician. The act of adjusting a written treatment protocol, goal, or target in the treatment plan is reported separately using 97180.

Q: What is adaptive behavior direction of technician with analysis?

A: Adaptive behavior direction of technician with analysis is a service delivered by a QHP face-to-face with one patient and one or more technicians involving:

- Active direction of the technician(s) while the technician(s) delivers a service (97148, 97149, 97153, 97154, 97159, 97160) to the patient to ensure the assessment or treatment procedures are implemented correctly, to correct errors in implementation, and/or to train the technician(s) to implement a modified protocol with the patient present; and/or
- Face-to-face observations and analysis to determine the need for potential adjustments to assessment protocols or treatment targets, goals, or protocols and to make such adjustments as needed. If the QHP determines that no adjustments are needed, that decision must be documented in the medical record.

Activities such as reviewing session notes from previous technician-administered treatment sessions and adjusting written protocols should not be reported with this code because they are non-face-to-face activities that do not require the patient to be present. Such services should be reported with 97180.

Q: What does the 2027 code book tell us about concurrent billing of 97155?

A: The 2027 code book provides clear direction regarding which codes can be billed concurrently with 97155:

> *"Any assessment or treatment service delivered by a technician(s) (97148, 97149, 97153, 97154, 97159, 97160). This service is administered by a physician or other QHP who is face-to-face with a single patient and directs a technician to implement an assessment or treatment protocol face-to-face with a patient."*

Q: Is 97155 still a dual-use code?

A: No. 97155 is used specifically and only for QHP direction of a technician with patient(s) present. When the QHP delivers treatment directly to a single patient without a technician present. code 97173 should be reported.

Q: When should 97155 be reported?

A: 97155 should be reported in the following instances and **ALWAYS** with another code:

- **Assessment of harmful behavior**-- When the QHP joins 2 - 5 technicians face-to-face with a patient and directs the technicians' implementation of harmful behavior assessment protocols, report 97155 with 97148 and 97149.
- **1:1 treatment by technician** -- When a QHP joins a technician and a patient face-to-face to direct the technician's implementation of treatment protocols, report 97155 with 97153.
- **Group treatment by technician --** When a QHP joins a technician and a group of patients face-to-face to direct the technician's implementation of group treatment protocols, report 97155 with 97154.
- **Treatment of harmful behavior** -- When a QHP joins 2 - 5 technicians face-to-face with a patient to direct the technicians' implementation of harmful behavior treatment protocols, report 97155 with 97159 and 97160.

Q: Must the QHP adjust the assessment protocol or the treatment protocol, targets, or goals to bill 97155?

A: No. The QHP's 97155 activities are focused on the direction of the technician and analysis of the potential need for adjusting treatment protocols, targets, or goals. If assessment and treatment protocols, targets, or goals are functioning effectively, the QHP must clearly document their analysis and direction activities and document the decision not to make adjustments in the medical record.

Q: How should the QHP's adjustment of written assessment or treatment protocols, targets, or goals be reported?

A: Clinical decision-making and adjustments of written assessment protocols or treatment targets, goals, or protocols that are made by the QHP when they are not-face-to-face with the patient may occur on the same or separate date from the delivery of face-to-face services. Those non-face-to-face services should be reported with code 97180. *Reminder: 97180 may be reported once each week, per patient, by summing the total amount of time spent on non-face-to-face clinical decision-making services during the preceding week. For reporting purposes, a week is defined as 7 days (e.g., Sunday to Saturday). The AMA rounding rule should be applied to each date of service separately, before the units for the week are summed and billed on a single claim line. See the illustrative infographic above.*

97173

Adaptive behavior treatment with analysis, administered by a physician or other QHP, face-to-face with 1 patient, each 15 minutes

TYPICAL PATIENT: A 12-year-old female presents with a history of deficits in adaptive behaviors and difficulties acquiring skills. She also engages in dropping to the ground and covering her eyes while humming loudly. Treatment with analysis is required for the physician or other QHP to determine if treatment targets, goals, and/or protocols need to be adjusted.

CLINICAL EXAMPLE:

Prior to the session: The QHP prepares for the session by gathering needed materials, preparing the treatment space, and reviewing the treatment protocols they will implement and analyze during the session.

During the session (face-to-face): The QHP implements the treatment protocols directly with the patient while analyzing the patient's responses. During the session, the QHP adjusts their delivery of treatment protocols for both skill acquisition and behavior reduction as needed, such as altering the nature and timing of prompts to increase the patient's independent performance.

After the session: The QHP records the time they spent face-to-face with the patient, summarizes what occurred during the session, and notes any adjustments to treatment protocols, targets, or goals that may be needed in the medical record consistent with payer policy requirements. If existing treatment protocols are functioning effectively and require no adjustment, that should be documented in the medical record as well.

Q: When should 97173 be reported?

A: 97173 is a new code to report the QHP providing 1:1 treatment to a patient with analysis. 97173 is administered by a physician or other QHP face-to-face with a patient. The physician or other QHP provides direct treatment and analyzes the need for potential adjustments to treatment targets, goals, or protocols and makes such adjustments, as needed.

Q: What is "analysis" as that term is used in this code descriptor?

A: Analysis is defined as the cognitive work done by the QHP during face-to-face delivery of treatment services to the patient. It involves the QHP observing the patient's responses to treatment protocols and determining if target behaviors and/or protocols need to be adjusted. This service requires the advanced training and competence of a QHP and may not be administered by a technician. The act of adjusting a written treatment protocol, goal, or target in the treatment plan is reported separately using 97180.

Q: If a technician cancels due to illness or other reasons and a QHP fills in to administer a treatment session to a patient, how should the QHP's time be reported?

A: If the QHP simply serves as a proxy for the technician, the service should be reported as 97153 even though the session was conducted by a QHP. If the QHP delivers adaptive behavior treatment by protocol **with analysis** to determine if there is a need to modify treatment targets, goals, or protocols, that service should be reported using 97173. *Note*: Some payers require the use of modifier codes to indicate that a QHP or higher-level service provider rendered a technician-administered code. Check payer policy manuals and contracts for specific guidance on the use of modifiers.

97156

Family adaptive behavior treatment guidance with analysis, administered by a physician or other QHP (with or without the patient present), including discussing protocols and treatment targets and/or training the caregiver(s) to implement assessment or treatment protocols with the patient, face-to-face with caregiver(s) for 1 patient, each 15 minutes

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

CLINICAL EXAMPLE:

Prior to the session: The QHP prepares for the session by gathering needed materials, preparing the treatment space, and selecting the treatment protocols they will implement and analyze during the session with the parents.

During the session (face-to-face): The QHP discusses the treatment protocol with the parents, which involves the use of prompting and reinforcement to promote the patient's use of picture cards and gestures to indicate his desire to stop an activity and to request help. The QHP demonstrates those procedures with the patient while the parents observe, then has each parent in turn implement the procedures with the patient while the QHP observes, provides feedback, and records data on the patient's performance. The QHP gives the parents a copy of the treatment protocol and data sheets with instructions for implementing the protocol during typical family routines.

After the session: The QHP records the time they spent face-to-face with the parents, summarizes what occurred during the session, and notes any adjustments that may be needed to treatment protocols, targets, or goals in the medical record consistent with payer policy requirements. If existing treatment protocols are functioning effectively and require no adjustment, that should be documented in the medical record as well.

Q: Why was this language, "including discussing protocols and treatment targets and/or training the caregiver(s) to implement assessment or treatment protocols with the patient" added to the code descriptor for 97156?

A: This language was added to the descriptor of 97156 to provide additional clarification for providers, payers, and clients/caregivers regarding which activities may occur when caregiver training is reported. Check-ins or conversations between a behavior analyst and a caregiver should only be reported as a billable service when they are related to their child/family member's treatment targets, possible future targets, or the caregivers' training on implementation of those targets/goals with the patient. If the caregiver reports a socially significant change that will impact the protocol for current or future caregiver training targets and goal development, the accompanying discussion, including analysis, may also be reported. The revised descriptor reinforces that 97156 represents a clinical treatment service involving caregiver guidance and QHP analysis, rather than general support or conversations unrelated to the patient's assessment or treatment.

Q: Can 97156 be reported for services delivered to parents while the patient is receiving direct treatment elsewhere (e.g., when the patient is in a treatment session with a technician and the parents are receiving training from the QHP in another room)?

A: Yes. Those are separate and distinct services delivered to different family members by different providers.

Q: Who constitutes a "caregiver?"

A: The 2027 code book broadens the definition of *caregiver* to include "a patient's parents or other family members, legal guardians, babysitters, nannies, teachers, or day care providers." Payers may have their own definition of *caregiver*.

Q: What is "analysis" as that term is used in this code descriptor?

A: Analysis is defined as the cognitive work performed by the QHP during the face-to-face delivery of treatment services to a caregiver(s). It involves the QHP observing and analyzing the caregiver's responses to treatment protocols and determining whether treatment targets and/or protocols need to be adjusted. This service requires the advanced training and competence of a QHP and may not be administered by a technician. Analysis that occurs during the face-to-face caregiver guidance is included in the service and reported using 97156. The act of adjusting a written treatment protocol, goal, or target in the treatment plan is reported separately using 97180.

97157

Multiple-family group adaptive behavior treatment guidance with analysis, administered by a physician or other QHP (without the patient present), face-to-face with multiple sets of caregivers for multiple patients, each 15 minutes

TYPICAL PATIENT: The parents of a 7-year-old male who has maladaptive behavior(s) and limited functional play, social, and communication skills seek training to address his maladaptive behavior(s) and help him develop skills in these areas. The physician or other QHP determines that it is appropriate to deliver some of the training to those parents in a group format along with caregivers of multiple patients who have similar treatment targets.

CLINICAL EXAMPLE:

Prior to the session: The QHP prepares for the session by gathering needed materials, preparing the treatment space, and reviewing the treatment protocols they will implement and analyze during the session with the group of caregivers.

During the session (face-to-face): The QHP reviews strategies for implementing functional communication training (FCT), models implementing an FCT protocol in a role-play, and then has the caregivers practice implementing the protocol with each other while the QHP provides feedback.

After the session: The QHP records the time they spent face-to-face with the caregivers, summarizes what occurred during the session, and notes any adjustments that may be needed to treatment protocols, targets, or goals in the medical record consistent with payer policy requirements. If existing treatment protocols are functioning effectively and require no adjustment, that should be documented in the medical record as well.

Q: What constitutes a "group?"

A: A group includes at least 2 patients. The prior group size maximum of 8 patients has been removed in the 2027 code set. The maximum group size is determined by the QHP based on the treatment needs of the patients in the group. The revised coding guidance does not set a group size limit. Any payer-specific administrative requirements are separate from CPT guidance.

Q: Should 97157 be reported for every attendee in the group session?

A: No. Report this code for each patient whose caregiver or set of caregivers attended the group session. For example, if one or both parents of each of five patients attended the group session, report the code once for each parent or set of parents. That is, 97157 should be reported for each single caregiver or set of caregivers who participated in a group session. To illustrate, if both of Susie's grandparents, both of John's parents, and Jack's mother participated, report 97157 once each for Susie, John, and Jack.

Q: **Our agency provides services for three siblings from the same family. Can 97157 be billed for each sibling with one caregiver participating in each session?**

A: No. This code is intended for services involving the caregivers of multiple patients. A single caregiver (or caregiver pair) participating in one session cannot be counted multiple times for their multiple children receiving services. If the session involves caregivers in only one family, report family adaptive behavior guidance code 97156 rather than the multiple-family group adaptive behavior guidance code 97157.

Q: What is "analysis" as that term is used in this code descriptor?

A: Analysis is defined as the cognitive work performed by the QHP during face-to-face delivery of treatment services. Analysis may involve the QHP discussing caregiver-reported information about treatment protocol implementation and patient responses, observing and analyzing caregivers as they practice or rehearse protocols through role-play or simulation; and determining whether target behaviors and/or protocols need to be adjusted. This service requires the advanced training and competence of a QHP and may not be administered by a technician. The act of modifying a written treatment protocol, goal, or target in the treatment plan is reported separately using 97180.

97158

Group adaptive behavior treatment with analysis, administered by a physician or other QHP, face-to-face with multiple patients, each 15 minutes

TYPICAL PATIENT: A 13-year-old female is reported to be isolated from and at risk of bullying by peers due to limited social and communication skills and a history of invading others' personal space. The physician or other QHP recommends adaptive behavior treatment with analysis delivered by the physician or other QHP in a small group of patients.

CLINICAL EXAMPLE:

Prior to the session: The QHP prepares for the session by gathering needed materials, preparing the treatment space, and reviewing the treatment protocols they will implement and analyze during the session.

During the session (face-to-face): The QHP begins the group session by asking each patient to briefly describe two of their recent social encounters with peers, one that went well and one that did not. The QHP uses that information to develop a group activity in which the patient has the opportunity to practice the skills she used in the encounters that went well and to problem solve interactions that did not go well. The QHP helps the patient identify social cues that were interpreted correctly and incorrectly and what she could have done differently and provides prompts and feedback. The QHP also records data on the patient's performance. The QHP ends the session by summarizing the discussion and skills that were practiced, answering questions, and giving the patient an assignment to practice a particular peer social skill and record her own performance of that skill.

After the session: The QHP records the time they spent face-to-face with the patient, summarizes what occurred during the session, and notes any adjustments needed to treatment protocols, targets, or goals in the medical record consistent with payer policy requirements. If existing treatment protocols are functioning effectively and require no adjustment, that should be documented in the medical record as well.

Q: Can 97154 and 97158 be reported concurrently?

A: No. 97158 is intended to be reported for QHP-led group treatment sessions only.

Q: Can 97155 and 97158 be reported concurrently?

A: Although coding edits do not currently exist to prevent these two codes from being reported together, it would be uncommon. Concurrent billing of 97155 and 97158 should occur only when a QHP joins another QHP who is leading group treatment for the purpose of directing the latter QHP on their implementation of treatment protocols specific to a particular patient attending the group session.

Q: What constitutes a "group?"

A: A group includes at least 2 patients. The prior group size maximum of 8 patients has been removed in the 2027 code set. The maximum group size is determined by the QHP based on the treatment needs of the patients in the group. The revised coding guidance does not set a group size limit. Any payer-specific administrative requirements are separate from CPT guidance.

Q: Should 97158 be reported for each patient in the group session?

A: Yes. Report this code for each patient attending the group session. Documentation should reflect the individualized treatment plan goals addressed with each patient during the group session.

Q: What is "analysis" as that term is used in this code descriptor?

A: Analysis is defined as the cognitive work done by the QHP during face-to-face delivery of treatment services to the patient(s). It involves the QHP observing the patient(s)' responses to treatment protocols and determining if target behaviors and/or protocols need to be adjusted. This service requires the advanced training and competence of a QHP and may not be administered by a technician. The act of modifying a written treatment protocol, goal, or target in the treatment plan is reported separately using 97180.

OTHER FREQUENTLY ASKED QUESTIONS

Q: Do all payers have to adopt the 2027 CPT codes for adaptive behavior/ABA services?

A: Yes. All of the codes in this set are now Category I CPT codes. Per HIPAA regulations, if a payer accepts claims electronically, they must utilize Category I CPT codes. HIPAA does not, however, govern whether a payer covers a code / service, what a payer pays for a code / service, or what a payer requires to authorize a code / service.

It is important to note that since there is no grace period, 0362T and 0373T are invalid for dates of service on or after January 1, 2027.

Q: What needs to happen before a provider can use the new codes?

A: Commercial payers must:

- add new codes to their claims system and publish billing guidance.
- update their fee schedule and / or issue a contract amendment.
- issue new authorizations and / or guidance if they will honor current authorizations that include deleted codes.

Medicaid state agencies should consider:

Rate development
↓
Fiscal + access analysis
↓
Determine whether SPA required
↓
Public/tribal process, if applicable
↓
CMS approval, if applicable
↓
MMIS implementation
↓
Fee schedule/provider manual updated
↓
Effective date (1/1/2027)
↓
Provider billing + state monitoring

Providers must:

- update their EHR and billing software,
- add new documentation templates,
- train staff on the use of the new codes and revised payer policies, and
- confirm timelines and processes with each payer.

Providers are encouraged to get written confirmation from each payer on timelines for implementation of the 2027 codes, as well as any revisions to reimbursement rates and authorization processes, prior to January 1, 2027.

Q: Are all payers required to implement the new CPT codes as of January 1, 2027?

A: No. Payers have their own procedures and timelines for implementing new codes, so providers must obtain that information from each payer with whom they work.

Q: Can 97155 be reported for treatment planning conducted by the QHP while the technician implements treatment with the patient?

A: No. Code 97155 should be reported only for services where the QHP is face-to-face and engaged with the technician(s) and the patient. The QHP reports 97155 when directing technicians on their implementation of assessment or treatment protocols. 97180 may be reported for ongoing non-face-to-face services the QHP typically provides during the course of a patient's treatment (e.g., training technicians to implement protocols without the patient present, adjusting the treatment plan or protocols based on analysis of data and session notes, developing discharge or transition plans).

Q: What is an example of how an authorization for a patient would change from 2026 (using the 2019 CPT code set) to 2027 (using the 2027 CPT code set) for adaptive behavior services?

A: The table below shows a sample 2026 authorization on the left and a 2027 authorization under the new code set on the right.

Patient A's 6-month Auth in 2026	Patient A's 6-month Auth in 2027
97151 – 48 units (12 hours)	**97151– 48 units** (12 hours)
97153 – 2080 units (20 hours per week for 26 weeks)	**97153 – 2080 units** (20 hours per week for 26 weeks)
97155 – TOTAL 312 units for 26 weeks • 208 units (2 hours per week for 26 weeks) for direction of technician w/ patient present • 104 units (1 hour per week for 26 weeks) for QHP to deliver 1:1 treatment w/ protocol modification to patient	**97155 - 208 units** (2 hours per week for 26 weeks) QHP direction of technician w/ patient
Currently reported using 97155	**97173 - 104 units** (1 hour per week for 26 weeks) for QHP to deliver 1:1 treatment w/ protocol modification to patient
Currently not reportable	**97180 – 52 units** (0.5 hours per week for 26 weeks) QHP non-face-to-face services
97156 – 104 units (1 hour per week for 26 weeks)	**97156 – 104 units** (1 hour per week for 26 weeks)

Q: Why do I need resources on the 2027 CPT code set if I have all the resources developed by the authors of this article?

A: The *CPT® 2027 Professional* code book contains information that is essential for a full understanding of the code set and how it should be reported. Those materials are copyrighted by the AMA, so they cannot be distributed without express permission from the AMA. Everyone who works with these CPT codes should obtain those resources from the AMA Store.

Q: What is the rounding rule and how does it apply to the adaptive behavior code set in 2027?

A: CPT codes are designated as "time-based" when they have a specific time increment indicated in the code descriptor. With time-based CPT codes, a service may be reported when half the time increment specified in the code descriptor has been met. All 2027 CPT codes for ABA services are timed in 15-minute increments, so work (direct delivery of services) lasting 8 - 22 minutes is reportable as one unit. Work lasting less than 8 minutes is not reportable.

Q: What is "direction" as that term is used in code 97155?

A: "Direction" in the context of code 97155 refers to the physician or other QHP directing the delivery of assessment or treatment to a patient by a technician. The focus is on ensuring that assessment and

treatment protocols are implemented correctly to maximize benefit to the patient. Direction of a technician includes but is not limited to the physician or other QHP providing instructions and feedback to the technician as needed and/or demonstrating correct implementation of an assessment or treatment protocol with the patient while the technician observes, followed by the technician implementing the protocol with the patient while the physician or other QHP observes and provides feedback. This service may be reported with 97155. Time reported for the service requires that: (a) the technician is face-to-face and actively engaged with the patient and (b) the physician or other QHP directs the technician on implementation of an assessment or treatment protocol. Technician time may be separately reported using 97148, 97149, 97153, 97154, 97159, 97160.

Q: What is "supervision"?

"Supervision" of a technician or other employee by a 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. Supervision activities that do not involve delivery of services directly to patients are generally not reportable or billable to health plans using CPT codes, though some payers may allow them to be billed using HCPCS or other codes. Activities that satisfy professional supervision or credentialing requirements may also qualify as reportable patient services when they independently meet the requirements of the applicable CPT code. For example, patient-focused direction of a technician by a QHP may be reported using 97155 when the code's requirements are met, even if the activity also satisfies applicable supervision requirements established by credentialing or regulatory bodies. The activity's eligibility for reporting is determined by the service delivered, not whether it also fulfills a supervision requirement. See Figure 1 below.

Figure 1. Direction versus supervision of a technician by a QHP

	Direction (97155)	Supervision
Who is involved	**QHP** → **Technician** → **Patient** *QHP directs the technician, who delivers the service to the patient.*	**QHP** → **Supervisee** *The supervisee may be a technician or other employee; supervision itself does not constitute billable patient services.*
Purpose	Ensure assessment and treatment protocols are implemented correctly to maximize benefit to the patient.	Ensure the supervisee practices competently, professionally, and ethically; follows employer policies; continues to develop; and receives personal support.
What it involves	Providing instructions and feedback to the technician and/or demonstrating the protocol with a patient while the technician observes, then observing the technician and giving feedback.	Includes activities to meet certification or license requirements or to fulfill ethical responsibilities. May also include supervisor's direct observation of technician delivering QHP-developed treatment protocols with a patient that are not for the benefit of a patient. **Some activities performed to meet supervision or credentialing requirements may also involve patient-specific direction of a technician that independently meets the requirements of 97155.*
Patient present?	**Yes** – the technician is face-to-face and actively engaged with the patient.	**Generally, no** – supervision activities generally do not involve delivering services directly to patients.
Reportable with CPT?	**Yes** – report with 97155. Technician time may be separately reported using 97148, 97149, 97153, 97154, 97159, 97160.	**Generally, no** – supervision activities are not independently reportable using CPT codes. However, activities that also meet the requirements of a patient service CPT code, such as 97155, may be reported under that code. Some payers may allow HCPCS or other codes.

Note: Direction and supervision are not necessarily mutually exclusive. Patient-focused direction of a technician that meets the requirements of 97155 may also satisfy applicable supervision requirements established by credentialing or regulatory bodies. However, meeting supervision requirements alone does not establish that an activity is reportable under CPT.

Q: Can adaptive behavior treatment by physician or QHP with analysis with a single patient (97173) be delivered concurrently with 97155?

A: No. Code 97173 includes analysis by the QHP. Reporting 97155 concurrently would be duplicative because the QHP rendering the 97173 service is conducting both 1:1 treatment with the patient and analysis of the patient's response to treatment. No additional analysis by a second QHP (97155) is necessary when 97173 is delivered.

Q: Can 97152 be reported concurrently with 97155?

A: No. 97152 is designed for technician implementation of behavior identification supporting assessment protocols they have been trained on by the QHP. The QHP reports their time training the technician on the assessment protocols without the patient present using code 97180. The QHP is not required to be present during 97152 supporting assessment sessions. If they elect to be present, their time is not billable.

Concurrent Billing Overview

This table summarizes **assessment and treatment codes with which code 97155 (QHP direction of technician) may be reported concurrently:**

Table 2. Codes that may be reported concurrently with 97155

Concurrent Billing with 97155	
97155 – direction of the technician is always paired with another code.	**97153** – individual treatment by a technician
	97154 – group treatment by a technician
	97148; **+97149** – Assessment of harmful behavior by 2 or more technicians
	97159; +97160 – Treatment of harmful behavior by 2 or more technicians
	97158 - may be reported concurrently with 97155 when one QHP joins another to direct the latter on implementing protocols with a specific patient in the group

**97155 may be reported concurrently with 97158 when one QHP joins another to direct the latter on implementing protocols with a specific patient in the group*

Code Usage and "Flow" Examples

Disclaimer: The information provided in the tables below is intended solely as illustrative examples of clinical circumstances that may occur. It is not exhaustive, should not be interpreted as the only available options, and must not be used to determine service activities or payor policy.

Table 3. Assessment services (97151, 97152, and 97180)

Shaded rows: non-face-to-face activity (no patient or caregiver present)

Day of Week	Provider	Patient present	Time	Code	Units	Details of Session
Mon	QHP	Yes	1:30–2:30 pm	**97151****	4	QHP meets with caregivers of a new patient to complete an adaptive behavior questionnaire or interview.
Tue	QHP	Yes	9:30–10:15 am	**97151**	3	QHP goes to the family home to conduct direct assessments of the patient to assess their skills in several domains. QHP conducts direct observation and recording of patient behaviors and administers direct and indirect assessment instruments.
Wed	QHP	No	12:45–1:15 pm	**97151**	2	QHP reviews results of the prior day's direct assessments.
	QHP	No	5–6 pm	**97151**	4	QHP begins writing the treatment plan and realizes they did not gather enough information to create goals and treatment protocols for some potential target behaviors. They determine that supplemental behavior identification assessment by technician (97152) is medically necessary and create or obtain protocols to be implemented by the technician.
Fri	QHP / Technician	No	9–9:30 am	**97180***	2	QHP trains the technician to implement the 97152 protocols correctly. In this example, 97180 is appropriate to capture the activity of training the technician in the absence of the patient.
Mon	Technician	Yes	10–11 am	**97152**	4	Technician conducts behavior identification supporting assessments. They document the patient's responses.
Tue	QHP	Yes	12–2 pm	**97151**	8	The QHP utilizes the data from the supporting assessments to identify potential target behaviors for the patient's treatment plan and meets with the patient and / or caregivers to go over the assessment results and finalize the treatment plan.

** A session note should be entered for each 97180 session. For billing purposes, only report once per week by summing the total time spent on non-face-to-face clinical decision-making, per patient, during the preceding 7 days. For reporting purposes, each week is considered 7 days (e.g, Sunday to Saturday).*

*** Remember that when reporting both 97151 and 97180 for a patient you should not count any non-face-to-face time for 97151 assessment activities in the units you report under 97180.*

Table 4. Treatment delivered to one patient in their home (97153, 97155, 97180)

Shaded rows: non-face-to-face activity (no patient or caregiver present)

Provider	Patient present	Time	Code	Units	Details of Session
Technician	Yes	8:30–11:30 am	**97153**	12	Technician conducts 1:1 treatment session with the patient in the home.
QHP	Yes	9:30–10:15 am	**97155**	3	QHP joins the technician and patient to direct the technician's implementation of the protocol and analyze whether any adjustments are needed. The QHP determines that the protocol needs to be revised to improve the patient's responses and new treatment targets need to be added to the treatment plan.
QHP	No	12:45–1:15 pm	**97180**	2	QHP returns to the office and modifies the treatment protocol and treatment plan.

Table 5. Treatment delivered to multiple patients in a center (97153, 97155, 97156, 97173, 97180)

Shaded rows: non-face-to-face activity (no patient or caregiver present)

Provider	Patient present	Time	Code	Units	Details of Session
Patient 1					
Technician	Yes	8:00–11:30 am	**97153**	14	Technician conducts 1:1 treatment with the patient in the center. Technician bills 97153
QHP	Yes	8:02–8:32 am	**97155**	2	QHP joins the technician and the patient to direct the technician to implement treatment protocols with the patient. QHP bills 97155 (concurrent).
Patient 2					
Technician	Yes	8:00 am–12:00 pm	**97153**	16	Technician conducts 1:1 treatment with the patient in the center. Technician bills 97153
QHP	No (caregivers present)	9:00–9:45 am	**97156**	3	QHP meets with the caregiver in their home via telehealth to train them to implement a new treatment protocol while the patient is receiving treatment from a technician at the center. QHP's time is reported with 97156 (concurrent).
Patient 3					
QHP	Yes	10:00–11:03 am	**97173**	4	QHP implements treatment protocols with the patient (includes QHP analysis).
Patient 4					
QHP	No	2:00–2:30 pm	**97180***	2	QHP trains the technician to implement two new treatment protocols with patient 4 prior to the patient's arrival for their 97153 session.
Technician	No	2:00–2:30 pm	**n/a**	n/a	Technician is trained by QHP, technician's time during NFTF training is not separately reported.
Technician	Yes	2:30–5:32 pm	**97153**	12	Technician conducts 1:1 treatment with the patient in the center.
QHP	Yes	2:30–3:37 pm	**97155**	4	QHP joins the technician and the patient to direct the technician on their implementation of treatment protocols, observe the patient's responses, and analyzes need for potential changes in treatment targets, goals, and/or protocols. QHP's time is reported with 97155 (concurrent).

** A session note should be entered for each 97180 session. For billing purposes, only report once per week by summing the total time spent on non-face-to-face clinical decision-making, per patient, during the preceding 7 days. For reporting purposes, each week is considered 7 days (e.g., Sunday to Saturday).*