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

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

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

Applied Behavior Analysis

Policy Number: CPCP011

Version 1.0

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Description

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

Reimbursement Information:

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

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

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

Guidelines (unless otherwise provided in the member's benefit) cont.:

Examples of customized, specialized and high-intensity settings include a means of separating from other patients, use of protective gear, padded isolation rooms with observation windows and medical protocols for monitoring patient during and after high intensity episodes, an internal/external review board to examine adverse incidents, access to mechanical/chemical restraint, and frequent external review to determine if the patient needs a higher level of care and whether this patient be safely treated in an outpatient setting. This service may be provided in day treatment, intensive outpatient day treatment or inpatient facilities, depending on the behavior. These services are not reimbursable, so providers should bill for encounter data purposes only.

- CPT code 97156 (Family Adaptive Behavior Treatment Guidance) is expressly for the QHP to meet face to face with the guardians/caregivers of the patient (with or without the patient present). This code should be reported when engaging in this activity rather than 97155, which is reserved for meetings with the patient.
- CPT codes are face to face and with one patient unless otherwise specified in the description. Billable supervision of a patient must be face to face and involves only one technician. There is no CPT code for indirect (patient not present) supervision activities (other than report writing- 97151 and family adaptive behavior treatment guidance- 97156).
- Documentation required to substantiate that services were rendered include but are not limited to: (1) a parent or caregiver's signature for each rendered service that also includes the service/code provided, rendering provider's name/signature, the date of service, and the beginning/end times of the service, (2) a written account, summary, or note of the service rendered, and (3) data point(s) regarding the Member's progress for the day.
- Case Supervision activities are comprised of both direct supervision (patient present) and indirect supervision (patient not present). Direct supervision includes the direction of Registered Behavior Technicians, treatment planning/monitoring fidelity of implementation, and protocol modification. Whereas indirect supervision includes developing treatment goals, summarizing and analyzing data, coordination of care with other professionals, report progress toward treatment goals, develop and oversee transition/discharge plan, and training and directing staff on implementation of new/revised treatment protocols (patient not present). The AMA codes for Adaptive Behavior Services indicate that the activities associated with indirect supervision are bundled codes and are otherwise considered a practice expense and not reimbursable. Although indirect supervision is a practice expense, documentation in the treatment plan of this service occurring is expected. The BACB (2014, pp. 31) recommends 20% of direct hours be spent in "Case Supervision activities" [both indirect and direct supervision combined] and 50% of this time be used for direct supervision. Direct supervision will be authorized at a minimum of 1 hour per week when less than 10 hours of direct services are authorized.

Guidelines (unless otherwise provided in the member's benefit) cont.

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

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

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

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

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

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

For example, if a provider renders:

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

Guidelines (unless otherwise provided in the member's benefit) cont.:

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

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

For example, if a provider renders:

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

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

Applied Behavior Analysis and Telehealth Supervision

NOTE: ***To pursue approval/authorization for ABA Telehealth supervision, the member MUST have: 1) telehealth benefit coverage; and 2) have ABA benefit coverage, then subsequently be approved for ABA treatment as medically necessary.***

Definitions

The American Telemedicine Association (2018) offers the following definitions:

[Telemedicine is]- the use of medical information exchanged from one site to another via electronic communications to improve patients' health status. Closely associated with telemedicine is the term "telehealth," which is often used to encompass a broader definition of remote healthcare that does not always involve clinical services. Videoconferencing, transmission of still images, e-health including patient portals, remote monitoring of vital signs, continuing medical education and nursing call centers are all considered part of telemedicine and telehealth.
Distance Site – A site where a health care provider who provides health care services is located while providing these services via a telecommunications system (i.e., QHP location).
Origination Site – A site where a patient is located at the time health care services are provided via a telecommunications system (i.e., location of the ABA services being conducted; in a practitioner office, or in a home setting with the client and direct therapist present).
Synchronous – A real-time interaction between a patient, direct therapist, and QHP located at a distant site.

Background

The focus of ABA treatment services relies on the use of 'observation' to measure changes for a client in skills to improve their functioning. The BACB states "ABA is a well-developed scientific discipline among the helping professions that focuses on the analysis, design, implementation, and evaluation of social and other environmental modifications to produce meaningful changes in human behavior. ABA includes the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. ABA uses changes in environmental events, including antecedent stimuli and consequences, to produce practical and significant changes in behavior." Therefore, the optimal and standard setting for conducting assessment and ABA services is 'face to face.'
The member would be seen face to face at a minimum of 4 times per year at approximately 3-month intervals. (This will include the functional assessments at 6-month periods to be face to face meetings.) There may be unique situations/circumstances where a member meets medical necessity for services, but due to geographic access reasons, the services are not available. In those unique situations, other options may be considered if all criteria outlined are met.

Telehealth Medical Necessity - Addendum to ABA Clinical Form Submission
Blue Cross Blue Shield (BCBS) members may be eligible for telehealth services only if: 1) they reside and will receive services from an originating site located in a rural Health Professional Shortage Area (HPSA) located in a rural census tract or 2) the provider/agency submits to BCBS documentation the distance between the facility/clinic location to the eligible recipient's location is at least 60 miles one-way (New Mexico Human Services Department, 2014).

> **Note:** If the road a QHP travels to access the location of the eligible recipient or member poses safety issues (dangerous winds/blowing dust, snowy or icy conditions) and there are challenges to accessing emergency services, flexibility may be given to the 60 miles one-way allowance. The QHP must describe this situation in the eligible recipient's or member's clinical file.

Case supervision must increase at least by one half-hour and up to 1 hour. This allows the QHP to have additional time to discuss and plan with the Behavior Technician/Direct Therapist the implementation of the ABA Treatment Plan protocols. Telehealth supervision will require, at a minimum, a face to face functional assessment of the member by the QHP every 6 months, preferably before the approaching new authorization period.

The QHP must document in the eligible recipient's or member's file that **without the use of telehealth technology the eligible recipient or member could not access medically necessary ABA services**.

The provider will need to complete the **ABA Supervision Via Telehealth Request & Attestation** form, obtained on the BCBS website, and send it in to review for this type of request.

Note:

1) Telehealth Supervision services at no time are simply utilized for the 'convenience' of the provider. It must be for the medical necessity of the member and their health needs.
2) At a date in the future, if a QHP is available for the member to access in their geographic area, then the telehealth request can be revisited.
3) Specific to approving ABA services utilizing telehealth services for supervision, there are additional telehealth set-up standards that would need to be met which are outlined below.

Telehealth Professional Set-up and Standards

The American Telemedicine Association (ATA) has set up recognized guidelines for effective and safe telehealth services. The expectation is a provider requesting to do supervision via telehealth will be meeting these guidelines in these topic areas:

1) State/federal legislation, regulations, accreditation and ethical standards for the telehealth service.
2) Provider must meet all the telehealth requirements for the state where the member resides.
3) Provider must meet all state (where member resides) and national requirements to provide supervision for ABA services.
4) Privacy and confidentiality (HIPAA) standards are being met with the electronic transmission method.
5) Patients and health professionals are aware of their rights and responsibilities with respect to utilizing this service.
6) Availability of high quality cameras (video and/or still as clinically appropriate for the intended application), audio, and related data capture and transmission equipment that is appropriate for the telehealth clinical encounter, and which meet any existing practice-specific guidelines. Devices **should** have up-to-date security software per the manufacturer's recommendations. Health professionals/organizations should use device management software to provide consistent oversight of applications, device and data configuration and security.
7) Real time interactive connectivity provides one-way or two-way live video services through consumer devices that use internet-based video conferencing software programs

Telehealth Supervision Authorization Approval Guidelines

- Telehealth supervision will require, at a minimum, an in person face to face functional assessment of the member by the QHP every 6 months, before the approaching new authorization period.
- Additionally, the member will be seen face to face at a minimum of 4 times per year at approximately 3-month intervals. (This will include the functional assessments at 6-month periods to be face to face meetings.)
- Indirect Services such as treatment planning, report writing, assessment and analysis of data, by QHP are bundled with 97151. If the QHP is directing the technician without the client present this is also bundled service and not billable.
- ABA supervision via telehealth will require an active authorization on file for the submitted dates of service for the claim to be paid.
- Submit claims for telehealth ABA supervision services using the appropriate ABA CPT codes (97155 or 97156 only) and a 95 modifier (Via a synchronous interactive audio and video telecommunications system)
- Submit claims for telehealth services using Place of Service (POS) 02: Telehealth: The location where health services and health related services are provided or received, through telehealth telecommunication technology.
- Member's policy must contain telehealth as a covered benefit.

Telehealth Supervision Authorization Approval Guidelines (cont.)

For additional information on Telemedicine Medical Services and Telehealth Services guidelines, refer to the applicable state plan's website and/or the state legislation, regulations.

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

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

*References: Medical Policies

Title	Policy Number
Applied Behavior Analysis (ABA)	**PSY301.021**

References:

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Policy Update History:

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