Clinical Policy: Applied Behavioral Analysis Documentation Requirements

Reference Number: CP.BH.105
Date of Last Revison: 11/23

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Applied Behavior Analysis (ABA) services must meet specific documentation requirements and adhere to applicable regulations, accreditation standards, and professional practice standards. Appropriate and accurate documentation is critical to providing member/enrollees with quality care, treatment planning and progress monitoring. It helps facilitate communication with all team members participating in the member/enrollee's plan of care, ensuring appropriate utilization reviews and regulatory reimbursement compliance.[1]

Policy/Criteria

I. It is the policy of Centene Advanced Behavioral Health and health plans affiliated with Centene Corporation® that, when a covered benefit, *requests for Applied Behavioral Analysis (ABA) services* contain all of the following documentation requirements:

A. Confirmed autism spectrum disorder (ASD) diagnosis according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5 TR) criteria or an appropriate diagnosis as otherwise specified according to state-defined ABA criteria;
B. Recommendation for treatment with ABA by a physician, psychologist, social worker, or another appropriately licensed health care practitioner working within their scope of practice and who is qualified to diagnose ASD and recommend ABA;
C. Completion of the treatment record prior to submission of a claim;
D. *Note identification* requirements for *all services rendered* include all the following:
    1. Name of provider organization, clearly visible at the top of each note;
    2. Member/Enrollee's name, listed on each page. Note: If the legal name differs from the preferred name, the legal name is noted at the top of the note. The preferred name should be noted in parentheses and used in the rest of the documentation;
    3. Date of birth (DOB) or unique identifier (UI);
    4. Date of rendered service;
    5. Date of note creation (if different from the date of rendered service);
    6. Time service was initiated (time in) and the time the service ended (time out);
    7. Pauses in services indicating the time the service was paused and the time it resumed;
    8. Location of services;
    9. Type/Code of service provided;
    10. Rendering clinician/technician's name, credentials, and dated signature;
    11. Identification of other individuals present, including both of the following. Note: PHI or PII data for non- member/enrollee should not be included. Check boxes may be used as applicable;
        a. Relationship to the member/enrollee;
        b. The number of individuals participating in group sessions. Note: The minimum number of participants in group adaptive treatment is two and the maximum amount is eight;

12. Summary of session activity;
13. Addendum (if applicable) includes the following:
    a. Clear reference to the clinical note it is intended to supplement;
    b. Date completed;
    c. Signature with credentials;

E. *Service activity note* to assist with creating the content of a comprehensive assessment, include, but are not limited to, one of the following:
1. Administration of assessments, including but not limited to the following:
    a. Preference assessments;
    b. Standardized testing;
    c. Criterion-referenced testing;
    d. Functional Behavior Assessment or Functional Analysis;
2. Scoring or analysis of standardized assessment(s);
3. Patient observation;
4. Data collection (qualitative and quantitative);
5. Records review;
6. Parent/Guardian interview;
7. Report writing;
8. Findings and recommendations;
9. Any additional assessment activities;

F. *Service activity note requirements for specific rendering providers* include one of the following:
1. Documentation by a technician includes:
    a. Criteria noted in I.C.;
    b. Primary target areas addressed;
    c. Summary of techniques used during the session;
    d. Barriers to treatment plan implementation;
2. Documentation by a qualified healthcare professional includes:
    a. Criteria noted in I.C.;
    b. Primary target areas addressed or observed during session;
    c. List of protocol modifications made, if applicable;
    d. Direction of technician(s), if applicable;
    e. Direct treatment with member/enrollee if applicable;
    f. Consultation or training with guardian(s)/caregiver(s), if applicable;
    g. Other activities as needed;

G. *Comprehensive assessment report* includes all of the following:
1. Criteria noted in I.A, I.C., and I.D.;
2. Purpose of referral;
3. Background information relevant to treatment, including but not limited to, the following:
    a. Relevant family history;
    b. Living situation;
    c. Primary language(s), list all of the following: language spoken in the home, language spoken with other family members, and language spoken outside of the home;
4. Developmental and medical history, include both of the following, if applicable:

   a. Developmental milestones or major medical issues (e.g., surgeries, allergies, and major illnesses);
   b. Treatment history and current medications, including purpose of medication;
5. Current involvement in other services, providing details such as schedule, provider and start date if applicable;
6. Treatment setting and environmental analysis;
7. Priority target behaviors, all of the following:
   a. Identification of priority behavior(s);
   b. Operational definition;
   c. Baseline data;
   d. Proposed goals and objectives;
8. Coordination of care, one of the following:
   a. Opportunities to coordinate relevant care with other professionals;
   b. Barriers to coordinate care, if applicable;
9. Service delivery recommendations, including service levels, separated by service type;

H. *Treatment plan* aligns with the behavioral assessment and includes all the following:
1. Clinical interview, including all of the following:
   a. Information on problem behaviors:
   b. Developing operational definitions of primary area of concern;
   c. Information regarding function of behavior;
2. Review of recent assessments/reports to include one of the following:
   a. Functional behavior assessments;
   b. Cognitive testing;
   c. Progress reports;
3. Assessments and procedure results as follows:
   a. Brief description of indirect and direct assessments (include purpose):
   b. Summary of findings (e.g., graphs, tables, or grids);
   c. Target behaviors to include:
      i. Priority behaviors;
      ii. Operational definition;
      iii. Baseline data;
4. Individualized goals with measurable target outcomes and timelines which include the following:
   a. Focused ABA and Comprehensive ABA, of the following:
      i. Treatment setting;
      ii. Instructional method to be used;
      iii. Operational definition of each behavior and skill;
      iv. Description of data collection procedures;
      v. Proposed goals and objectives includes all of the following:
         a) Current level (baseline);
         b) Behavior parent/caregiver is expected to demonstrate, including condition under which it must be demonstrated and mastery criteria (the objective or goal);
         c) Date of introduction;
         d) Estimated date of mastery;

e) Specify plan for generalization;
f) Report goal as met, not met, modified (include explanation);

b. Parent/Caregiver training that is performance-based and caregiver-driven;
c. Number of service hours requested:
   i. Number of hours needed for each service;
   ii. Clinical summary that justifies hours requested for each service;
   iii. Billing codes requested (CPT, HCPCS);
d. Coordination of care, all of the following. Note: Providers must adhere to appropriate HIPPA and consent protocols when sharing information:
   i. Date(s) of coordination attempt(s);
   ii. Whether the attempt was successful;
   iii. The name of the contact;
e. Transition/Titration/Discharge plan includes all the following:
   i. Specific titration goals and plan indicating how service hours will be titrated;
   ii. Individualized, realistic and specific goals for discharge;
   iii. Updated progress towards attainment of transition/discharge goals achieved over authorization period;
   iv. Recommended services member/enrollee can access upon discharge;
f. Crisis plan;

5. Discharge summary includes all of the following, if applicable:
   a. Referrals provided;
   b. Progress summary (to include data and graphs as applicable);
   c. Rationale/reason for discharge;
   d. Date of discharge.

Background

Core Characteristics of Applied Behavioral Analysis (ABA)[2]:

According to the Council of Autism Service Providers (CASP), the following are considered the core characteristics of Applied Behavioral Analysis (ABA) and should be apparent throughout all phases of assessment and treatment:

1. An objective assessment and analysis of the member/enrollee's condition by observing how the environment affects one's behavior, as evidenced through appropriate data collection.
2. Importance given to understanding the context of the behavior and the behavior's value to the individual, the family, and the community.
3. Utilization of the principles and procedures of behavior analysis such that the member/enrollee's health, independence, and quality of life are improved.
4. Consistent, ongoing, objective assessment and data analysis to inform clinical decision-making.

Assessment Practice Elements:

1. Comprehensive assessment that describes specific levels of behavior at baseline and informs subsequent establishment of treatment goals.
2. An emphasis on understanding the current and future value (or social importance) of behavior(s) targeted for treatment.
3. A practical focus on establishing small units of behavior that build towards larger, more significant changes in functioning related to improved health and levels of independence.

4. Collection, quantification, and analysis of direct observational data on behavioral targets during treatment and follow-up to maximize and maintain progress toward treatment goals.
5. Efforts to design, establish, and manage the social and learning environment(s) to minimize. problem behavior(s) and maximize rate of progress toward all goals.
6. An approach to the treatment of problem behavior that links the function of (or the reason for) the behavior to the programmed intervention strategies.
7. Use of a carefully constructed, individualized, and detailed behavior-analytic treatment. plan that utilizes reinforcement and other behavioral principles and excludes the use of methods or techniques that lack consensus about their effectiveness based on evidence in peer-reviewed publications.
8. Use of treatment protocols that are implemented repeatedly, frequently, and consistently across environments until discharge criteria are met.
9. An emphasis on ongoing and frequent direct assessment, analysis, and adjustments to the treatment plan (by the Behavior Analyst) based on client progress as determined by observations and objective data analysis.
10. Direct support and training of family members and other involved professionals to promote. optimal functioning and promote generalization and maintenance of behavioral improvements.
11. A comprehensive infrastructure for supervision of all assessment and treatment by a Behavior Analyst.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2022, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Providers should reference the most recent version of ABA Coding Coalition for information on Medically Unlikely Edits (MUEs), and related processes for code usage and descriptors. The Centers for Medicare & Medicaid Services guidelines should be used to determine the maximum units of service a provider can report under most circumstances during a single date of service.[4]

CPT®* Codes	Description
97151	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/ interpreting the assessment, and preparing the report/treatment plan
97152	Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-

CPT®* Codes	Description
	to-face with one patient, each 15 minutes
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes
0362T	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior
0373T	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits. destructive behavior; completion in an environment that is customized to the patient's behavior

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed	11/23	11/23

References

1. Behavioral Health Center of Excellence – Standard for the Documentation of Clinical Records for Applied Behavior Analysis Services. https://www.bhcoe.org/standard/bhcoe-standard-101-standard-for-the-documentation-of-clinical-records-for-applied-behavior-analysis-services/. Published November 23,2020. Accessed October 24, 2023.
2. The Council of Autism Service Providers (CASP) Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers, 2nd Edition. https://assets-002.noviams.com/novi-file-uploads/casp/pdfs-and-

documents/ASD_Guidelines/ABA-ASD-Practice-Guidelines.pdf. Updated 2020. Accessed October 24, 2023.
3. Behavior Analyst Certification Board (BACB). https://www.bacb.com/. Published August 7, 2014. Accessed October 24, 2023.
4. ABA Coding Coalition Model Coverage Policy for Adaptive Behavior Services https://abacodes.org/wp-content/uploads/2020/09/Model-Coverage-Policy.pdf. Published 2020. Accessed October 24, 2023.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.