Clinical Policy: Applied Behavioral Analysis Documentation Requirements

Reference Number: CA.CP.BH.105
Date of Last Revision: 12/24

Coding Implications
Revision Log

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

Description

This clinical policy outlines the documentation requirements for applied behavioral analysis treatment services within California Health Net plan based off the medically necessary behavioral health treatment (BHT) services for members/enrollees under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, as outlined in APL 23-005 and APL 23-010 or any superseding APL, and in accordance with mental health parity requirements.[1,2]

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 plan of care, ensuring appropriate utilization reviews and regulatory reimbursement compliance.[3]

Policy/Criteria

I. It is the policy of Health Net and Centene Advanced Behavioral Health that, when a covered benefit, documentation for *Applied Behavioral Analysis (ABA) services* contain all of the following requirements:
- A. The member/enrollee is < 21 years of age;
- B. Recommendation from a licensed physician, surgeon, or psychologist;
- C. The member/enrollee is medically stable;
- D. The member/enrollee with intellectual disabilities, does not need 24 hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility;
- E. Service will be provided and supervised by one of the following providers:
  1. Qualified autism service provider;
  2. Qualified autism service professional;
  3. Qualified autism service paraprofessional;
- F. Service type documentation meets one of the following:
  1. *Behavior assessment report,* completed prior to requesting treatment services, includes all of the following:
     - a. Record review;
     - b. Clinical interview;
     - c. Risk/safety assessment (as applicable);
     - d. At least one of the following:
       - i. Functional analysis assessment;
       - ii. Skills based assessment;
       - iii. Standardized assessment;
     - e. Assessments from other professionals (as applicable);

f. Scoring or analysis of standardized testing (norm referenced and/or criterion referenced);
g. Treatment setting and environmental analysis;
h. Direct observation and measurement of behavior (continuous and discontinuous);
i. Priority target behaviors, all the following:
    i. Identification of priority behavior(s);
    ii. Operational definition;
    iii. Baseline data;
    iv. Proposed goals and objectives;

2. *Initial treatment* records include all of the following:
    a. A treatment plan, completed by one of the providers listed in I.E, aligns with the behavior assessment and includes all of the following:
        i. Individualized goals and objectives with measurable target outcomes and timelines, considering all of the following:
            a) Member/enrollee's age;
            b) Current level (baseline);
            c) Operational definition of target behavior and skills;
            d) Interventions focused on active core symptoms and specific plan for generalization;
            e) Date of introduction;
            f) Estimated date of mastery;
            g) Treatment setting (home, community-based setting or school);
        ii. Number of hours or units requested includes all of the following:
            a) Direct service to the member/enrollee includes one of the following:
            b) Focused ABA, 10 to 25 hours;
            c) Comprehensive ABA, 30 to 40 hours;
            d) Parent/caregiver training;
            e) Case supervision;
            f) Assessment;
        iii. Coordination of care includes both of the following:
            a) Identifies each alternative provider who is responsible for delivering services (as applicable);
            b) Dates and outcomes from coordination of care efforts;
        iv. Crisis Plan;
        v. Transition/Titration/Discharge plan includes all of the following:
            a) Specific titration goals and plan indicating how service hours will be titrated;
            b) Individualized, realistic and specific goals for discharge;
            c) Updated progress towards goals achieved over the authorization period;
            d) Rationale or reason for discharge with a statement indicating that under the EPSDT medical necessity criteria, "services will be reduced or discontinued when services no longer have an ameliorative or maintenance purpose";
            e) Recommended services member/enrollee can access upon discharge;
        vi. Signature, credential, and role of each person who reviewed and signed the plan;

3. *Continuation treatment records* include all the following:
    a. An updated behavior assessment and treatment plan, completed every six months (or less, as clinically appropriate, or as state mandated), describing all of the following:
        i. Changes in treatment goals and interventions to include all the following:
            a) Data and graph representation of mastery of skills noted in the treatment plan;
            b) Changes in scores on standardized assessments over time;
            c) Changes from the initial treatment plan;
            d) Outcome measures of treatment goals;
    b. Transition plan which includes monitoring and evaluation details;
    c. Collaboration and coordination in care with other providers;

G. Service activity notes are completed prior to claim submission includes both of the following:
1. Services provided by specific rendering providers, documents of the following:
    a. A *registered technician's* note, identifies all of the following:
        i. Primary target areas addressed;
        ii. Summary of techniques used during the session;
        iii. Barriers to treatment plan implementation;
    b. A *qualified healthcare professional's* note identifies all of the following:
        i. Primary target areas addressed or observed during session;
        ii. List of protocol modifications made, if applicable;
        iii. Direction of technician(s), if applicable;
        iv. Direct treatment with member/enrollee if applicable;
        v. Consultation or training with guardian(s)/caregiver(s), if applicable;
        vi. Other activities as needed;
2. All notes must include all of the following *identification information*:
    a. Name of provider organization, clearly visible at the top of each note;
    b. 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;
    c. Date of birth (DOB) or unique identifier (UI);
    d. Date of rendered service;
    e. Date of note creation (if different from the date of rendered service);
    f. Time service was initiated and the time the service ended;
    g. Pauses in services (indicating the time the service was paused and the time it resumed);
    h. Location of services;
    i. Type/Code of service provided;
    j. Rendering clinician/technician's name, credentials, and dated signature;
    k. Identification of all individuals actively participating during the session to include the relationship to the member/enrollee. Note: PHI or PII data for non-member/enrollee should not be included.
    l. Summary of session activity;
    m. Addendum (if applicable) includes the following:

i. Clear reference to the clinical note it is intended to supplement;
ii. Date completed.

II. It is the policy of Health Net and Centene Advanced Behavioral Health that, when a member/enrollee no longer meets medical necessity criteria, a discharge summary is submitted which includes all of the following, (as, applicable):
A. Referrals provided;
B. Progress summary (to include data and graphs as applicable);
C. Rationale/reason for discharge;
D. Date of discharge.

Background
Behavior health treatment (BHT) services for the treatment of autism spectrum disorder (ASD) are described in California's Medicaid State Plan. BHT services include applied behavioral analysis (ABA) and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction.[2]

California Department of Health Care Services. All Plan Letter (APL) 23-005[1]
For additional information on EPSDT requirements, including the definition of "Medically Necessary," see APL 23-005: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21, or any superseding APL.

For additional information on mental health parity, see APL 22-006: Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services, or any superseding APL.

All APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
California's Medicaid State Plan is available at:
https://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx.

The Council of Autism Service Providers (CASP) Applied Behavior Analysis Treatment of Autism Spectrum Disorder[3]
Core Characteristics of Applied Behavioral Analysis (ABA):
1. Objective assessment and analysis of the person's condition by observing how the environment affects their behavior, as evidenced through appropriate measurement.
2. Understanding the context of the behavior and the behavior's value to the person, their caregivers, their family, and the community.
3. Promotion of the person's dignity.
4. Utilization of the principles and procedures of behavior analysis to improve the person's health, skills, independence, quality of life, and autonomy.
5. Consistent, ongoing, objective data analysis to inform clinical decision making.

Essential Practice Elements of Applied Behavior Analysis (ABA):
1. A comprehensive assessment that describes specific levels of behavior(s) at baseline and informs the subsequent establishment of meaningful treatment goals.

2. An emphasis on understanding the current and future value or social importance of behavior(s) targeted for treatment.
3. Reasonable efforts toward collaboration with the person receiving treatment, their guardians if applicable, and those who support them (e.g., caregivers, care team) in developing meaningful treatment goals.
4. A practical focus on establishing small units of behavior that build toward larger, more significant changes in abilities related to improved health, safety, skill acquisition, and/or levels of independence and autonomy.
5. Collection, quantification, and analysis of direct observational data on behavioral targets during treatment and follow-up to maximize and maintain progress toward treatment goals.
6. Design and management of social and learning environment(s) to minimize challenging behavior(s) and maximize the rate of progress toward all goals.
7. An approach to the treatment of challenging behavior that links the function(s) of, or the reason(s) for, the behavior with programmed intervention strategies.
8. Use of a carefully constructed, individualized, and detailed behavior-analytic treatment plan that utilizes reinforcement and other behavioral principles and excludes methods or techniques not based on established behavioral principles and theory.
9. Use of treatment protocols that are implemented repeatedly, frequently, and consistently across environments until discharge criteria are met.
10. An emphasis on frequent, ongoing analysis and adjustments to the treatment plan based on patient progress.
11. Direct training of caregivers and other involved laypersons and professionals, as appropriate, to support increased abilities and generalization and maintenance of behavioral improvements.
12. A comprehensive infrastructure for case supervision by a behavior analyst of all assessments and treatment.

ABA Coding Coalition[4]

The American Medical Association (AMA) defines a qualified healthcare professional (QHP) for purposes of reporting medical services as follows: "A 'physician or other qualified health care professional' is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service." The following professionals are approved providers, credentialed to practice independently:

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

These approved providers may be assisted by a Licensed Assistant Behavior Analysts (where applicable) or Board-Certified Assistant Behavior Analysts® and behavior technicians (paraprofessionals) who implement treatment plans under the supervision of professional behavior analysts.[4]

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 2023, 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-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

CPT®* Codes	Description
	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

HCPCS ®* Codes	Description
H0031	Mental health assessment, by nonphysician, per 15 minutes
H0032	Mental health service plan development by nonphysician, per 15 minutes
H2014	Skills training and development, per 15 minutes
H2019	Therapeutic behavioral services, per 15 minutes
S5111	Home care training, family; per session

Reviews, Revisions, and Approvals	Revision Date	Approval Date
New policy adapted from CP.BH.500, based off based off the Medically Necessary Behavioral Health Treatment (BHT) services for members/enrollees under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, as outlined in APL 23-005 or any superseding APL, and in accordance with mental health parity requirements.	12/24	12/24

References

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2. California Department of Health Care Services. All Plan Letter (APL) 23-010. https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-010.pdf. Published November 22,2023. Accessed November 7, 2024
3. The Council of Autism Service Providers (CASP) Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers, Third Edition. https://www.casproviders.org/standards-and-guidelines. Updated April 29, 2024. Accessed November 7, 2024..
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standard-101-standard-for-the-documentation-of-clinical-records-for-applied-behavior-analysis-services/. Published January 01,2021. Accessed November 7, 2024.
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7. Center for Medicare and Medicaid Services. Clarification of Medicaid Coverage of Services to Children with Autism. https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-07-14.pdf. Published November 7. 2024. Accessed October 18, 2024.
8. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents. https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf. Published June 2014. Accessed October 18, 2024.
9. The Council of Autism Service Providers (CASP) Practice Parameters for Telehealth-Implementation of Applied Behavior Analysis, 2nd Edition. https://assets-002.noviams.com/novi-file-uploads/casp/pdfs-and-documents/Final-Copy-Practice-Parameters-Telehealth-ABA-AMA-References-12_2_2199.pdf. Updated December 1, 2021.Accessed November 7, 2024.

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 documentation 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.