Applied Behavior Analysis (ABA) Frequently Asked Questions (FAQ)

If a member is receiving services under an MCO and then changes to FFS, what is the correct way to request authorization for services to FFS? Is there a grace period if we were unaware of the change in coverage?

If the MCO has authorized the specific service and dates but the recipient changed to FFS, please include authorization documentation from the MCO in your authorization request to Nevada Medicaid. The authorization from the MCO will be considered in decisioning the authorization request.

If the recipient's eligibility changes from MCO to FFS after the service is provided, but the eligibility is backdated to cover the actual date of service, an authorization request is required to be submitted as noted above (a). The authorization request must be received within 30 calendar days of receipt of the Explanation of Benefits from the MCO indicating the change.

If a member was previously receiving services with a different provider and transfers to our agency, what is the process to submit the prior authorization?

The steps are outlined below:

- Verify recipient eligibility
- Check Treatment History for assessments in the previous 180 days (97151, 97152)
- If there is no assessment within the previous 180 days, authorization is not required for these 2 codes.
- If there is an assessment within the previous 180 days, include the appropriate assessment code on the FA-11E form and document the date of the previous assessment in section VII.
- If another agency has an active prior authorization, the Recipient/Recipient's Guardian will need to fill out the FA-29A form to provide a discharge date, or the current agency will need to provide the FA-29 form to terminate the prior authorization to prevent overlapping dates of service.
- Complete the FA-11E form, with or without assessment codes, along with the FA-11F form.
- Create the prior authorization request in the PWP.
- Attach both FA forms and IEP, if applicable, to the authorization request then submit.

As a provider filling out an FA-29A form for a new client, how do we know what codes were approved for the previous agency?

The Recipient or Recipient's Guardian can contact Gainwell Prior Authorization Customer Service (800) 525-2395 to request the list of codes.

How do we explain the need for units when a Board Certified Behavior Analyst (BCBA) and Board Certified Assistant Behavior Analyst (BCaBA) are rendering the services, if needed?

The prior authorization request should consist of 2 separate lines for the applicable procedure code: one that includes modifier UD and one that does not. When claims are submitted, you will bill with the applicable code and modifier based on the provider that rendered the service.

If needed, you may transfer units from one line of an approved prior authorization to redistribute available units with and without the UD modifier.

Does a BCBA get reimbursed differently than an Registered Behavior Technician (RBT) performing the same service?

Yes, BCBA's are reimbursed at a different rate than RBT's. Refer to the spreadsheet on the NVHA/Rates Unit webpage for a list of reimbursement rates for PT 85/all specialties.

How do we indicate a service that was rendered in two places, such as family training that takes place in both the home and office settings?

You can designate the training location by using the appropriate Place of Service (POS) code on your claim line.

What digital signatures are accepted?

Nevada Medicaid accepts HIPAA compliant tools that allow for digital signatures, please refer to Web Announcement 1908.

Where are service limitations specified?

Service limitations are outlined in the Medicaid Services Manual, Chapter 3700- Applied Behavior Analysis as well as in the Billing Guidelines for PT 85.

Can an LCSW refer members to our agency?

All referring providers should be acting within the scope of their practice and following clinical guidelines within their area of expertise regarding referrals.

When am I able to use the previous version of the FA11-F form?

- If providers have completed a previous FA-11F form, they are not required to complete another form. To remain compliant with the Nevada Medicaid Medical Record Documentation Policy, providers using a previous form should ensure that the recipient's name, date of service, and page number(s) are written onto each page being submitted.
- For any diagnosis prior to 8/1/2025, the most updated form must be used.

How do we upload the IEP as one document?

The maximum file size when uploading an attachment to a PA is 4 MB per submission. If you receive an error message that your file exceeds this limitation, here are some steps to try:

- Compress the PDF file.
- Split the file into multiple sections/ documents and upload them separately. To do this, upload the first file (within the size limit) and submit the PA request. To upload additional files, go back to the existing PA number and select the Edit button. Scroll down to the attachments and attach additional files. Repeat as needed.

Can we bill for the same service (same recipient and DOS) under two different NPIs?

No, all hours should be reported and billed under the NPI that has the majority of units. Providers should ensure that they have clear documentation that includes the provider that treated the recipient that day, including start/end times, services, and any other documentation requirement needed for their records.

Should prior authorization requests be submitted under the group or the individual?

PA requests should be submitted with the group NPI - this allows an alternative provider to render services if needed.

How many hours can I use for supervision?

The maximum number of units that can be used for supervision is 20% of the **total** number of hours of direct therapy services provided.

Is the FA-11F only required once? Who is required to sign the form?

Yes, the diagnosis should only be completed one time, and the diagnosis is to be reported on the FA-11F form. This is to be signed by the diagnosing physician that is ordering the services (must be a Physician, Physician's Assistant, Advanced Practice Registered Nurse (APRN) or Psychologist acting within their scope of practice).