Applied Behavior Analysis (ABA)

State Policy

The Medicaid Services Manual (MSM) is on the Division of Health Care Financing and Policy (DHCFP) website at http://dhcfp.nv.gov (select "Manuals" from the "Resources" webpage).

- MSM Chapter 3700 covers policy for Applied Behavior Analysis (ABA) providers.
- MSM Chapter 1500 covers policy for the Healthy Kids Program.
- MSM Chapter 400 covers policy for behavioral health providers.
- MSM Chapter 100 contains important information applicable to all provider types.

Rates

Reimbursement rates for Applied Behavior Analysis (ABA) provider type 85 are listed online on the DHCFP website on the Rates webpage. Rates are also available on the Provider Web Portal at www.medicaid.nv.gov through the Search Fee Schedule function, which can be accessed on the Provider Login (EVS) webpage under Resources (you do not need to log in).

EPSDT Screenings for All Children Include Autism Spectrum Disorder

The Centers for Medicare & Medicaid Services (CMS) released guidance on July 7, 2014, indicating all children must receive Early Periodic Screening, Diagnostic and Treatment (EPSDT) screenings designed to identify health and developmental issues, which include Autism Spectrum Disorder (ASD). Currently, Nevada Medicaid and Nevada Check Up cover developmental screens (Current Procedural Terminology (CPT) code 96110) which are provided by Special Clinics (provider type (PT) 17), Physicians (PT 20), Advanced Practice Registered Nurses (PT 24) and Physician's Assistants (PT 77).

Authorization Requirements

Authorization is required for most behavioral health services, including those referred through the EPSDT program. Use the Authorization Criteria search function in the Provider Web Portal at www.medicaid.nv.gov to verify which services require authorization. Authorization Criteria can be accessed on the Provider Login (EVS) webpage under Resources (you do not need to log in).

- Behavioral Initial Assessment and re-assessments do not require prior authorization. Assessments are limited to one in every 180 days or unless prior authorized.
- Adaptive Behavioral Treatment (individual and group) requires prior authorization.

For questions regarding authorization, call Nevada Medicaid at (800) 525-2395 or refer to MSM Chapter 3700. Prior authorization may be requested through the Nevada Medicaid Provider Web Portal:

- Form FA-11E: Applied Behavior Analysis (ABA) Authorization Request
- Form FA-11F: Autism Spectrum Disorder (ASD) Diagnosis Certification for Requesting Initial Applied Behavior Analysis (ABA) Services

Incomplete prior authorization requests cannot be processed. Incomplete prior authorization requests will be pended to the provider for additional information. The submitter will have five business days to supply the missing information, or a technical denial will be issued.

Authorization does not guarantee payment of a claim. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program.

Limits for Authorizations

Focused Delivery Model: 15-25 hours per week for all ABA services. Focused ABA is treatment directly provided to the individual for a limited number of specific behavioral targets.

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Comprehensive Delivery Model: 25-40 hours per week for all ABA services. Comprehensive ABA is treatment provided to the individual for a multiple number of targets across domains of functioning including cognitive, communicative, social and emotional.

Session limits may be exceeded with prior authorization and documentation of medical necessity. Requests above the policy limits will be reviewed on a case-by-case basis at the provider request.

Supervision is allowed up to 20% of the treatment hours.

Request timelines

- **Initial request**: Providers are instructed to submit the initial request no more than 15 *business* days *before* and no more than 15 *calendar* days *after* the start date of service.
- **Continued service requests**: If the recipient requires additional services or dates of service (DOS) beyond the last authorized date, you may request review for continued service(s) prior to the last authorized date. The request must be received by Nevada Medicaid by the last authorized date, and it is recommended these be submitted 5 to 15 days prior to the last authorized date.
- **Unscheduled revisions**: Submit whenever a significant change in the recipient's condition warrants a change to previously authorized services. Must be submitted during an existing authorization period and prior to revised units/services being rendered. The number of requested units should be appropriate for the remaining time in the existing authorization period.
- **Retrospective request**: Submit no later than 90 days from the recipient's Date of Decision (i.e., the date the recipient was determined eligible for Medicaid benefits). All authorization requirements apply to requests that are submitted retrospectively.

Billing and Claim Instructions

Each service provided must be billed with the National Provider Identifier (NPI) of the actual provider of the service, not the supervising clinician.

Each individual servicing provider may provide billable services for no more than 12 hours on any given day.

Claims must be submitted with diagnosis code F84.0 (Autism Spectrum Disorder) or diagnosis code Q86.0 (Fetal alcohol syndrome).

Date span billing is not permitted.

Providers permitted to bill the PT 85 billing codes include:

- PT 85 (Applied Behavioral Analysis)
- PT 60 (School Health Services)
- PT 47 (Indian Health Services/Tribal Clinics/Tribal FQHCs)

Use Direct Data Entry (DDE) or the 837P electronic transaction to submit claims to Nevada Medicaid. For billing instructions, see the Electronic Verification System (EVS) Chapter 3 Claims on the EVS User Manual webpage and the Transaction 837P companion guide, which is located on the Electronic Claims/EDI webpage.

Ordering, Prescribing or Referring (OPR) Provider Requirements

The Patient Protection and Affordable Care Act and the Centers for Medicare & Medicaid Services (CMS) require all ordering, prescribing and referring physicians to be enrolled in the state Medicaid program (§455.410 Enrollment and Screening of Providers). The Affordable Care Act (ACA) requires physicians or other eligible practitioners to enroll in the Medicaid program to order, prescribe and refer items or services for Medicaid recipients, even when they do not submit

claims to Medicaid. Physicians or other eligible professionals who are already enrolled in Medicaid as participating providers and who submit claims to Medicaid are not required to enroll separately as OPR providers.

For any services or supplies that are ordered, prescribed or referred, the NPI of the Nevada Medicaid-enrolled Ordering, Prescribing or Referring (OPR) provider must be included on Nevada Medicaid/Nevada Check Up claims or those claims will be denied. To prevent claim denials for this reason, please confirm that the OPR provider is enrolled with Nevada Medicaid; this can be done on the Provider Web Portal by using the Search Providers feature: https://www.medicaid.nv.gov/hcp/provider/Resources/SearchProviders/tabid/220/Default.aspx

Electronic Claims instructions: When reporting the provider who ordered services such as diagnostic and lab, use Loop ID-2310A. For ordered services such as Durable Medical Equipment, use Loop ID-2420E. For detailed information, refer to the 837P FFS Companion Guide located at: https://www.medicaid.nv.gov/providers/edi.aspx

Direct Data Entry/Provider Web Portal instructions: On the Service Detail line enter the OPR provider's NPI in the Referring/Ordering Provider ID field and select "Yes" or "No" to indicate it if is an Ordering Provider. For further instructions, see the Electronic Verification System (EVS) User Manual Chapter 3 located at: https://www.medicaid.nv.gov/providers/evsusermanual.aspx

Covered Services

The table on the following pages lists covered codes, code descriptions, and prior authorization / billing information as needed. For coverage and limitations, refer to MSM Chapter 3700.

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ABA Services					
Code	**Description**	**Unit**	**Session Limit**	**Prior Authorization**	**Do Not Report: List is not all inclusive; please review billing rules**
Assessments					
97151	Behavior identification assessment, administered by a physician or other qualified healthcare professional, each 15 minutes of the physician's or other qualified healthcare 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	15 minutes	1 session of 16 units per 180 days	Not required	on same day in conjunction with: 90785 -- 90899, 96101 -- 96125, 96150, 96151, 96152, 96153, 96154, 96155, H0031
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 the patient, each 15 minutes	15 minutes	1 session of 4 units per 180 days	Not required	on same day in conjunction with: 90791, 90792, 90785 -- 90899, 96101 -- 96125, 96150, 96151, 96152, 96153, 96154, 96155, H0032

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Code	Description	Unit	Session Limit	Prior Authorization	Do Not Report: List is not all inclusive; please review billing rules
0362T	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: • administered 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 • completed in an environment that is customized to the patient's behavior • Per the American Medical Association (AMA) CPT 2022 Codebook, code 0362T is reported based on a single technician's face-to-face time with the patient and not the combined time of multiple technicians [e.g., one hour with three technicians equals one hour of service].	15 minutes	1 session of 4 units per 180 days	Not required	on same day in conjunction with: 90785 -- 90899, 96101 -- 96125, 96150, 96151, 96152, 96153, 96154, 96155, H0032
Adaptive Behavior Treatment – Individual Limit of 40 hours per recipient per week combined, regardless of NPI for CPT codes: 97151- 97155, 0362T, 97153-97155, 0373T, 97156-97158					
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	15 minutes		Required	in conjunction with: 90785 -- 90899, 92507, 96105 -- 96171, 97129, H2014, H2019, H2017, H2017 HQ
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	15 minutes		Required	in conjunction with: 90789 -- 90899, 92507, 96015 -- 96171, 97129, H2014, H2019, H2017, H2017 HQ

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Code	Description	Unit	Session Limit	Prior Authorization	Do Not Report: List is not all inclusive; please review billing rules
0373T	Adaptive behavior treatment by protocol with modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: • 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 • Per the American Medical Association (AMA) CPT 2022 Codebook, code 0373T is reported based on a single technician's face-to-face time with the patient and not the combined time of multiple technicians [e.g., one hour with three technicians equals one hour of service].	15 minutes		Required	in conjunction with: 90789-90899, 96015, 96110, 96116, 96121, 96156, 96158, 96159, 96164, 96156, 96167, 96168, 96170, 96171, H2014, H2019, H2017, H2017 HQ

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Code	Description	Unit	Session Limit	Prior Authorization	Do Not Report: List is not all inclusive; please review billing rules
Adaptive Behavior Treatment – Group and/or Family					
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	15 minutes		Required	if group is larger than 8, in conjunction with: 90785 -- 90899, 92508, 96105 -- 96171, 97150, H2014, H2019, H2017, H2017 HQ
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	15 minutes		Required	if the group is larger than 8, in conjunction with: 90785 -- 90899, 96105 -- 96171, 90853, 92508, 97150, H2014, H2019, H2017, H2017 HQ
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	15 minutes	1 session of 4 units per week	Required	in conjunction with: 90785 -- 90899, 96105 -- 96171, 90791, 90792, 90846, 90847, 90887, H2014, H2019, H2017, H2017 HQ, S5110, S5110 HQ
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (without the patient present), face-to-face with multiple sets of guardian(s)/caregiver(s), each 15 minutes	15 minutes	1 session of 4 units per calendar month	Required	in conjunction with: 90785 -- 90899, 96015 -- 96171, 92508, 97150, H2014, H2019, H2017, H2017 HQ