Washington State Health Care Authority

Washington Apple Health (Medicaid)

Applied Behavioral Analysis (ABA) Program Billing Guide

(For clients age 20 and younger)

January 1, 2020

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

About this guide*

This publication takes effect January 1, 2020, and supersedes earlier guides to this program.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

> Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

What has changed?

Subject	Change	Reason for Change
Entire guide	Hyperlink and typographical error corrections, and general housekeeping	To improve usability
Behavioral Health Organization (BHO)	Removed this section	Effective January 1, 2020, behavioral health services in all regions will be provided under integrated managed care.
Integrated Managed Care Regions	Effective January 1, 2020, integrated managed care is being implemented in the last three regions of the state: • **Great Rivers** (Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties) • **Salish** (Clallam, Jefferson, and Kitsap counties) • **Thurston-Mason** (Mason and Thurston counties)	Effective January 1, 2020, HCA completed the move to whole person care to allow better coordination of care for both body (physical health) and mind (mental health and substance use disorder treatment, together known as "behavioral health"). This delivery model is called Integrated Managed Care (IMC).

* This publication is a billing instruction.

How can I get agency provider documents?

To access provider alerts, go to the agency's provider alerts webpage.

To access provider documents, go to the agency's provider billing guides and fee schedules webpage.

Where can I download agency forms?

To download an agency provider form, go to HCA's Billers and Providers webpage, select Forms & publications. Type the HCA form number into the **Search box** as shown below (Example: 13-835).

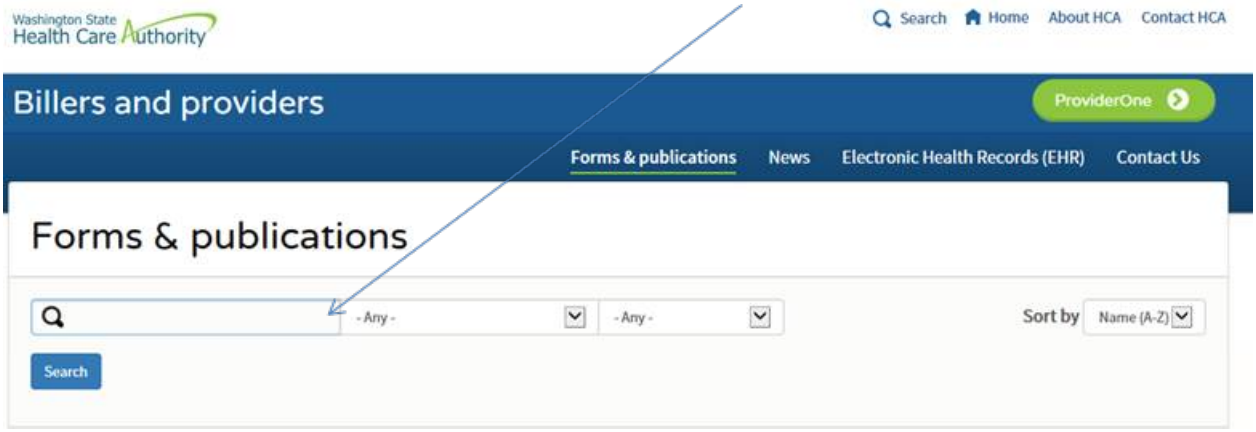

Table of Contents

Alert! This **Table of Contents** is automated. Click on a page number to go directly to the page.

Alert! This **Table of Contents** is automated. Click on a page number to go directly to the page.

Resources Available

Topic	Resource
Prior Authorization (PA) or Limitation Extension (LE)	For all requests for PA or LE, the following documentation is required: • A completed, TYPED, General Information for Authorization form, HCA 13-835. This request form MUST be the initial page when you submit your request • A completed Applied Behavior Analysis Services request form, HCA 12-411, for initial PA requests and recertification. • A completed Assessment and Behavior Change Plan form, HCA 13-400, for PA requests and recertification. For information about downloading agency forms, see Where can I download agency forms?
Becoming a provider or submitting a change of address or ownership	See the agency's ProviderOne Resources webpage
Contacting Provider Enrollment	
Finding out about payments, denials, claims processing, or agency managed care organizations	
Electronic billing	
Finding agency documents (e.g., billing guides, fee schedules)	
Private insurance or third-party liability, other than agency-contracted managed care	
Access E-learning tools	See the agency's ProviderOne Resources webpage
More information	See the agency's Autism and Applied Behavior Analysis (ABA) therapy webpage

Definitions

This list defines terms and abbreviations, including acronyms, used in this billing guide. Refer to Chapter 182-500 WAC for a complete list of definitions for Washington Apple Health.

Autism diagnostic tool - A tool used to establish the presence (or absence) of autism and to make a definitive diagnosis, which will be the basis for treatment decisions and the development of a treatment plan.

Examples of autism diagnostic tools include:

- Autism diagnosis interview (ADI).
- Autism diagnostic observation schedule (ADOS).

Autism screening tool - A tool used by a primary care provider to detect indicators or risk factors for autism and may indicate a suspicion of the condition, which would then require confirmation, which would then require a referral to a Center of Excellence for confirmation.

Examples of screening tools include:

- Ages and stages questionnaire (ASQ).
- Communication and symbolic behavior scales (CSBS).
- Parent's evaluation and developmental status (PEDS).
- Modified checklist for autism in toddlers (MCHAT).
- Screening tools for autism in toddlers and young children (STAT).

Comprehensive treatment model – A model that meets a child's individual needs in addressing core symptom areas of autism and related disorders, disrupts challenging behaviors, and builds a foundation for learning-readiness across multiple domains of functioning.

Diagnostic and Statistical Manual of Mental Disorders (DSM-5) **-** The manual published under this title by the American Psychiatric Association that provides a common language and standard criteria for the classification of mental disorders.

Managed care organization (MCO) – See WAC 182-538-050.

National Provider Identifier (NPI) – See WAC 182-500-0075**.**

Program Overview

Who should read this guide?

This guide contains instructions for:

- Centers of Excellence (COEs) who conduct the clinical diagnostic evaluation, and
- Applied behavior analysis (ABA) providers offering ABA services.

This guide may also be helpful to primary care providers who want to assist children and their families in accessing ABA services and navigating the pathway to care.

What is ABA?

ABA is an approach to improve behavior and skills related to core impairments associated with autism and a number of other developmental disabilities. ABA therapy involves application of validated principles of human behavior to change inappropriate behaviors. Providers monitor and measure how well therapy is working using validated methods. ABA therapy also focuses on social significance, which promotes a family-centered, whole-life approach.

What is the purpose of the ABA program?

WAC 182-531A-0100

Apple Health includes coverage for ABA services for children age 20 and younger to address the core symptoms associated with autism spectrum disorders or other developmental disabilities. ABA services support learning and assist with the development of social, behavioral, adaptive, motor, vocational, and cognitive skills.

Client Eligibility

Most Apple Health clients are enrolled in an agency-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See the agency's Apple Health managed care page for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Apple Health.** For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's ProviderOne Billing and Resource Guide.

If the patient is eligible for Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. **Verify service coverage under the Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see the agency's Program Benefit Packages and Scope of Services webpage.

Note: Patients who are not Apple Health clients may submit an application for health care coverage in one of the following ways:

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org

2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)

3. By mailing the application to:
   Washington Healthplanfinder
   PO Box 946
   Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

Are clients enrolled in an agency-contracted managed care organization (MCO) eligible?

Yes. Most Medicaid-eligible clients are enrolled in one of the agency's contracted managed care organizations (MCOs). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an agency-contracted MCO must be obtained by the client through designated facilities or providers. The MCO is responsible for:

- Payment of covered services
- Payment of services referred by a provider participating with the plan to an outside provider

Note: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 182-502-0160.

Note: To prevent billing denials, check the client's eligibility **prior** to scheduling services and at the **time of the service**, and make sure proper authorization or referral is obtained from the agency-contracted MCO, if appropriate. See the agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

Managed care enrollment

Apple Health (Medicaid) places clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program they are eligible for. However, some clients may still start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Medicaid eligibility determination.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care. Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's Get Help Enrolling page.

- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's policies.

Apple Health – Changes for January 1, 2020

Effective January 1, 2020, the Health Care Authority (HCA) completed the move to whole-person care to allow better coordination of care for both body (physical health) and mind (mental health and substance use disorder treatment, together known as "behavioral health"). This delivery model is called Integrated Managed Care (formerly Fully Integrated Managed Care, or FIMC, which still displays in ProviderOne and Siebel).

IMC is implemented in the last three regions of the state:

- **Great Rivers** (Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties)
- **Salish** (Clallam, Jefferson, and Kitsap counties)
- **Thurston-Mason** (Mason and Thurston counties)

These last three regions have plan changes, with only Amerigroup, Molina, and United Healthcare remaining. There are changes to the plans available in these last three regions. The only plans that will be in these regions are Amerigroup, Molina, and United Healthcare. If a client is currently enrolled in one of these health plans, their health plan will not change.

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account**:
  Go to Washington HealthPlanFinder website.

- **Available to all Apple Health clients:**

  - ✓ Visit the ProviderOne Client Portal website:

  - ✓ Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

  - ✓ Request a change online at ProviderOne Contact Us (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."

For online information, direct clients to HCA's Apple Health Managed Care webpage.

Clients who are not enrolled in an agency-contracted managed care plan for physical health services

Some Medicaid clients do not meet the qualifications for managed care enrollment. These clients are eligible for services under the FFS Medicaid program. In this situation, each Integrated Managed Care (IMC) plan will have Behavioral Health Services Only (BHSO) plans available for Apple Health clients who are not in managed care. The BHSO covers only behavioral health treatment for those clients. Clients who are not enrolled in an agency-contracted managed care plan are automatically enrolled in a BHSO, with the exception of American Indian/Alaska Native clients. Some examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption support and Foster Care alumni.

Integrated managed care (IMC)

Clients qualified for managed care enrollment and living in integrated managed care (IMC) regions will receive all physical health services, mental health services, and substance use disorder treatment through their agency-contracted managed care organization (MCO).

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care; or
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS]).

If a client does not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the agency's American Indian/Alaska Native webpage.

For more information about the services available under the FFS program, see the agency's Mental Health Services Billing Guide and the Substance Use Disorder Billing Guide.

For full details on integrated managed care, see the agency's Apple Health managed care webpage and scroll down to "Changes to Apple Health managed care."

Integrated managed care regions

Clients residing in integrated managed care regions and who are eligible for managed care enrollment must choose an available MCO in their region. Details, including information about mental health crisis services, are located on the agency's Apple Health managed care webpage.

Region	Counties	Effective Date
Great Rivers	Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum	January 1, 2020
Salish	Clallam, Jefferson, Kitsap	January 1, 2020
Thurston-Mason	Thurston, Mason	January 1, 2020
North Sound	Island, San Juan, Skagit, Snohomish, and Whatcom	July 1, 2019
Greater Columbia	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima, and Whitman	January 1, 2019
King	King	January 1, 2019
Pierce	Pierce	January 1, 2019
Spokane	Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties	January 1, 2019
North Central	Grant, Chelan, Douglas, and Okanogan	January 1, 2018 January 1, 2019 (Okanogan)
Southwest	Clark, Skamania, and Klickitat	April 2016 January 1, 2019 (Klickitat)

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care of Washington's (CCW) Apple Health Foster Care program receive both medical and behavioral health services from CCW.

Clients under this program are:

- Under the age of 21 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

These clients are identified in ProviderOne as
"**Coordinated Care Healthy Options Foster Care.**"

The Apple Health Customer Services staff can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact the agency's Foster Care Medical Team at 1-800-562-3022, Ext. 15480.

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see the agency's Mental Health Services Billing Guide, under *How do providers identify the correct payer*?

Provider Eligibility

WAC 182-531A-0800

Who may provide services under the applied behavior analysis (ABA) program?

Two types of providers deliver services under the ABA program:

- Centers of Excellence (COE)
- Applied behavior analysis (ABA) therapy service providers

What is a Center of Excellence (COE)?

A COE is a hospital, medical center, or other health care provider that meets or exceeds standards set by the agency for specific treatments or specialty care. In this program, a COE performs the clinical diagnostic evaluation to determine whether ABA services are appropriate for an individual child. The COE provides the required diagnostic documentation, evidence of medical necessity, and an order for ABA services to the agency or the managed care organization (MCO).

What are the qualifications for a COE?

All COE providers must meet the following qualifications and comply with applicable state laws.

- A COE may be a person or an organization.
- The COE must be enrolled with the agency or the client's MCO, unless the client has third-party insurance.
- The COE's evaluating and prescribing providers must function as a multidisciplinary team whether facility-based or practitioner-based.

The COE must either be or employ a person licensed by the Department of Health (DOH) as one of the following:

- A person licensed under Title 18 RCW who is experienced in the diagnosis and treatment of autism spectrum disorders and is one of the following:

  - ✓ A developmental pediatrician
  - ✓ A neurologist
  - ✓ A pediatric neurologist
  - ✓ A pediatric psychiatrist
  - ✓ A psychiatrist
  - ✓ A psychologist

Or

- A qualified medical provider who has been designated by the agency as a COE

The COE must be prequalified by the agency as meeting or employing people who meet all of the following criteria:

- ARNPs, physicians, and psychologists must have demonstrated expertise in diagnosing an autism spectrum disorder by doing one of the following:

  - ✓ Using a validated diagnostic tool
  - ✓ Confirming the diagnosis by observing the client's behavior and interviewing family members
  - ✓ Reviewing the documentation available from the client's primary care provider, individualized education plan, or individualized family service plan

- ARNPs, physicians, and psychologists must understand the medically necessary use of ABA services

- ARNPs, physicians, and psychologists must be sufficiently qualified to conduct and document a comprehensive diagnostic evaluation, and develop a multidisciplinary clinical treatment plan under WAC 182-531A-0500(2)

Examples of providers who can qualify as a COE include:

- Multidisciplinary clinics
- Individual qualified provider offices
- Neurodevelopmental centers

How does a provider become recognized as a COE?

To apply to become a COE, contact the ABA program manager at ABA@hca.wa.gov. To be recognized as a COE by the agency, the provider must submit a signed *COE Attestation* form, HCA 13-0009, to the agency by email at ABA@hca.wa.gov. (See Where can I download agency forms?)

Training is offered in various locations for physicians, ARNPs and interested community members based on interest and trainer availability. Contact the ABA program manager at ABA@hca.wa.gov to request COE training or if your region is interested in hosting a COE training.

Will the agency accept an evaluation that was not completed by a COE?

In limited circumstances the agency may, at its discretion, accept an evaluation from a qualified medical provider who is not a recognized COE. For the agency to consider accepting an evaluation from such a provider, the provider must have performed a clinical diagnostic evaluation and agree to provide the required documentation to the agency.

> **Example:** The agency will consider accepting a recent autism evaluation from a pediatric psychiatrist who evaluated a Medicaid-covered child if the child's primary insurance paid for the autism evaluation but will not pay for ABA therapy services.

Who can apply to provide ABA services?

Health care professionals with the following credentials offered through the Department of Health are eligible to provide Apple Health-funded ABA services:

- Licensed Behavior Analyst (LBA)
- Licensed Assistant Behavior Analyst (LABA)
- Certified Behavior Technician (CBT)

See the DOH ABA credential webpage for qualifications and application process.

Who can enroll with the agency as a lead behavior analysis therapist (LBAT)?

WAC 182-531A-0800

To be enrolled as an LBAT, an applicant must be free of license restrictions, in good standing with DOH, and be a:

- DOH-licensed behavior analyst (LBA);
- DOH-licensed assistant behavior analyst (LABA) with supervision from a LBA as defined by the BACB standards; or
- DOH-licensed mental health counselor, DOH-licensed marriage and family therapist, DOH-licensed independent clinical social worker, DOH-licensed advanced social worker, or DOH-licensed psychologist and have a signed *Applied Behavior Analysis (ABA) Attestation* form, HCA 13-0008, regarding certification as a board-certified behavior analyst (BCBA) or a board-certified assistant behavior analyst (BCaBA) on file with the agency.

Additional requirements for LBAT enrollment

LBATs must meet both of the following:

- Have a signed core provider agreement (CPA) with the agency
- Be authorized to supervise ancillary providers

How do providers enroll with the agency as a certified behavior technician (CBT)?

WAC 182-531A-0800

To enroll with the agency as CBT, an applicant must be:

- Free of license restrictions, and
- In good standing with DOH

AND one of the following:

- Certified by DOH as a CBT; or
- A DOH-licensed mental health counselor, DOH-licensed marriage and family therapist, DOH-licensed independent clinical social worker, DOH-licensed advanced social worker, or DOH-licensed psychologist and have a signed *Applied Behavior Analysis (ABA) Attestation* form, HCA 13-0008, regarding ABA training and experience on file with the agency.

Additional requirements for CBT enrollment

All CBTs must have a core provider agreement (CPA) with the agency.

Becoming a facility-based day treatment program

WAC 182-531A-0600(3)(a)

To apply to become an agency-approved day treatment program, complete and submit the *ABA Day Program Capacity Attestation* form, HCA 13-0007. (See Where can I download agency forms?). This form is required to evaluate whether applicants meet program guidelines. This form must be completed by a provider in collaboration with the agency upon the initiation and any expansion of day treatment capacity. Send questions and the completed form to HCAABA@hca.wa.gov.

Accessing ABA Services

What is the applied behavior analysis (ABA) pathway to care?

The agency uses a case management approach, creating a pathway of care to deliver ABA services for eligible children. This approach has three main stages. The stages of the pathway of care are:

Stage one: Referral to a Center of Excellence (COE) for an evaluation
Stage two: If ABA services are ordered, parents identify and select an ABA provider
Stage three: Delivery of ABA therapy services

Stage one of the pathway to care

WAC 182-531A-0500

Referral

The first stage of the ABA program starts with a referral to a COE for an evaluation. Anyone can refer a child to a COE, including:

- The child's primary care provider.
- Another licensed health care practitioner.
- A school-based health care professional.
- An early intervention health care professional.
- The child's family.
- The child's managed care organization, if the child has one.

Note: Many COEs require a referral from the child's primary care provider (PCP).

Note: COE evaluations for children who are enrolled in a managed care organization (MCO) may require prior authorization from the MCO.

What does the COE do?

Following the referral, the COE provides a comprehensive diagnostic evaluation and develops multidisciplinary clinical treatment recommendations that may include an order for ABA. If the COE concludes ABA is an appropriate treatment that will likely benefit the child, the COE will write an order for ABA services. The COE will provide a copy of this order and the supporting documentation to the caregiver, who will then provide it to the selected ABA provider.

Required documentation

The agency requires that the COE provider complete and submit all of the following:

- The report of the comprehensive diagnostic evaluation, including treatment recommendations
- The COE order
- The DSM-5 checklist

The comprehensive diagnostic evaluation

WAC 182-531A-0500 (2) and (3)

The comprehensive diagnostic evaluation must include:

- Results of routine developmental screening performed by the child's primary care provider at well child visits, if available.
- Audiology and vision assessment results, if available, or documentation that vision and hearing were determined to be within normal limits during assessment and not a barrier to completing a valid evaluation.
- The name of the completed autism screening questionnaire, including date completed and significant results, if available.
- Documentation of how the diagnosis was made or confirmed by a COE physician or psychologist that includes one of the following:
    - ✓ Results of formal diagnostic procedures performed by a clinician, including name of measure, dates, and results, as available

- ✓ Clinical findings and observations used to confirm the diagnosis. The child's health care record may incorporate family member observations establishing the presence of any of the core symptoms of an autism spectrum disorder: Functional impairment; delay in communication, behavior, or social interaction; or repetitive or stereotyped behavior.

- If available, documentation of a formal cognitive or developmental assessment performed by the COE or another qualified clinician that includes the name of the measure, dates, results, and standardized scores providing verbal, nonverbal, and full-scale scores. This may include school or early childhood education records. Examples of these assessment tools include the current version of the:

  - ✓ Mullen Scales of Early Learning
  - ✓ Wechsler Individual Achievement Test
  - ✓ Bayley Scales of Infant and Toddler Development

- If available, documentation of a formal adaptive behavior assessment performed by the COE or another qualified clinician, including name of the measure, dates, results, and standardized scores providing scores of each domain. Examples of these assessment tools include the current version of the:

  - ✓ Vineland Adaptive Behavior Scales
  - ✓ Adaptive Behavior Assessment System (ABAS)

- Expanded laboratory evaluation, if indicated

- Documentation that the client's behaviors or skill deficits are having an adverse impact on development or communication, or demonstrating injurious behavior, so that one of the following applies:

  - ✓ The client cannot adequately participate in home, school, or community activities because behavior or skill deficit interferes with these activities.

  - ✓ The client presents a safety risk to self or others. Examples include self-injury, aggression towards others, and destruction of property, stereotyped or repetitive behaviors, or elopement.

- Documentation that all of the following are met, if ABA services are ordered as part of the multidisciplinary treatment recommendations:

  - ✓ Less intrusive or less intensive behavioral interventions have been tried and were not successful.

  - ✓ There is no equally effective alternative available for reducing interfering behaviors, increasing prosocial behaviors, or maintaining desired behaviors.

- ✓ The full range of autism treatments was considered, with ABA services as a treatment component, if clinically indicated.

- ✓ The evaluating and prescribing provider believes there is a reasonable calculation that the requested ABA services will result in measurable improvement in the client's behavior or skills.

The COE provider will direct the family to the online link to find a Medicaid-enrolled ABA provider in the family's area. The family should contact their agency-contracted MCO, if enrolled, for providers authorized within their specific plan.

The COE will provide a copy of this order and the supporting documentation to the selected ABA provider.

Stage two of the pathway to care

WAC 182-531A-0600

Selecting an ABA provider

In Stage Two of the ABA pathway to care, the child's parent or guardian contacts Medicaid-enrolled ABA providers in the family's area. For children enrolled in an agency-contracted MCO, the parent or guardian should contact their plan to identify approved providers for that plan. The parent or guardian should contact as many of these providers as possible because some providers have waitlists. The agency does not choose the child's ABA provider.

Parent training only while the child is on a waitlist for individual ABA services

1. The client meets with the ABA provider with a copy of their COE evaluation and order.
2. The LBAT completes an assessment of the child to:

    - Confirm medical necessity and readiness for treatment; and

    - Develop a treatment plan. In the case of Parent training only, the LBAT will complete only the parent treatment goals portion of the treatment plan with goals for the parent to achieve related to the child's assessment. Contact the specific managed care plan to determine the requirements for preauthorization of parent-only training.

Note: All plans have agreed that pre-authorization will not be necessary for parent training provided after the child has been approved for the ABA benefit or any ABA services – whether that training is provided during the child's individual treatment or alone after successful completion of ABA Day Treatment.

Note: For a list of resources that may assist families with a child on a waitlist, see the agency's ABA therapy benefit.

The ABA assessment and treatment plan

After a parent or guardian and an ABA provider agree to work together, the LBAT completes a behavioral assessment using the *Assessment and Behavior Change Plan* form, HCA 13-400. See Where can I download agency forms?

Rationale for the treatment plan should be reflected in the body of the assessment and should include:

- Background and history, which must include all of the following:

  - ✓ The client's age, gender, language, race and ethnicity.
  - ✓ Past psychiatric history.
  - ✓ Chief complaint and History of Present Illness (HPI).
  - ✓ Family history.
  - ✓ Social history.
  - ✓ Medical history.
  - ✓ Educational history.
  - ✓ Past and current services.

- Assessments completed for evaluation, which must include all of the following:

  - ✓ Measures used.
  - ✓ Evaluation findings.
  - ✓ Functional behavior assessment and analysis findings.
  - ✓ Goal domains derived from assessment.

- A brief overview of the treatment plan, which must include all of the following:

  - ✓ How ABA will be applied to the client (e.g., will include home and community based 1:1 intervention for twenty hours per week to target social, communication, and adaptive goals).
  - ✓ Whether a positive behavior support plan is required to address challenging behaviors.
  - ✓ Specific and measureable goals for the parent or caregiver to achieve.
  - ✓ How the treatment plan will be coordinated with other providers.

- A maintenance, generalization, and discharge plan. This plan must include a statement about how maintenance and generalization will be addressed, how services will be faded, or how the client will be transitioned into other less intensive services (such as school, outpatient). At intake, this statement may be broad, but should become more specific as the client progresses in therapy. The fading plan should be specific, data-driven, and include criterion for discharge.

  Note: During the discharge planning process, programs should make every effort to involve service providers receiving the child into their care following discharge. When possible, this should be done through face-to-face case conferences.

  ✓ For day treatment program clients, the maintenance, generalization, and discharge plan should address all of the following:

  - Except in certain circumstances, children will be discharged from the program after 48 service days normally provided within a 12-week period.
  - Programs should begin discharge planning upon a child's admission in order to minimize the gap in services between programs due to waiting lists.
  - If there will be a gap in services (e.g., due to waiting lists) day treatment programs should attempt to provide follow-up consultation to the family on an outpatient basis, as needed, until community-based services are implemented.

- Goals and objectives for skill acquisition, which must include baseline or progress for each goal.

  Note: Before starting the ABA therapy described in the treatment plan, the ABA provider must obtain prior authorization (PA) from the agency or agency-contracted MCO. The PA request, including the assessment and ABA therapy treatment plan, must be received by the agency within 60 days of the family scheduling the functional assessment. For more information, see the Authorization section of this guide. If the child is enrolled in an agency-contracted MCO, follow the guidelines for the specific MCO. Send copies of the COE evaluation and order with the first prior authorization request.

Stage three of the pathway to care

WAC 182-531A-0700

In Stage Three of the ABA pathway to care, ABA services begin. Once the provider receives prior authorization from the agency, the ABA therapy treatment plan is implemented by the lead behavior analysis therapist (LBAT) or a certified behavior technician (CBT), or both, in conjunction with other care team members. The LBAT and the CBT each have a distinct role in providing ABA services.

LBAT responsibilities

WAC 182-531A-0800 (7)

The LBAT must do all of the following:

- Develop and maintain a comprehensive ABA therapy treatment plan that incorporates treatment being provided by other health care professionals, and states how treatment will be coordinated. The LBAT must sign the treatment plan.
- Share the treatment plan with the client's family and obtain their signed approval.
- Communicate and collaborate with other care team members to assure consistency in approaches to achieve treatment goals.
- Provide required training to parent(s) or caregiver(s).
- Supervise a minimum of five percent of the total direct care per week provided by the CBT (e.g., one hour of supervision per twenty hours of care).

Note: If indicated, the LBAT may also complete all of the responsibilities of the CBT. See CBT responsibilities.

CBT responsibilities

WAC 182-531A-0800 (10)

If a CBT is involved in delivering ABA therapy services, the CBT must do all of the following:

- Be supervised by an LBAT.
- Deliver services according to the ABA therapy treatment plan, whether in an individual or group setting.
- Encourage family members to use their training to support generalization and maintenance of achieved behaviors.
- Ensure family involvement through modeling and coaching.
- Review the client's progress with the LBAT at least every two weeks to confirm that the ABA therapy treatment plan still meets the child's needs. If changes are clinically indicated, they must be made by the LBAT.
- Consult with the LBAT when considering modification to technique, when barriers and challenges occur that prohibit implementation of plan, and as otherwise clinically indicated.

- Keep documentation of each visit with the client and family to include targeted behavior, interventions, response, modifications in techniques, and a plan for the next visit, along with behavior tracking sheets that record and graph data collected for each visit.

- Maintain signed and dated documentation of family's confirmation that a visit occurred.

ABA delivery methods and settings

Although ABA is principally provided one-to-one, the provider may choose to provide treatment in a group setting to accomplish specific goals for each child. ABA services can also be delivered in a variety of settings, depending on the program, the provider, and the child's needs. ABA services may be home-based, center-based, occur in a community setting, such as a school, a daycare, or a playground, or be delivered in an authorized day treatment program. A provider may even choose to deliver therapy in a combination of these settings to accomplish the treatment goals.

Community-based program services

Community-based program services are provided in homes, offices, clinics, and natural settings such as schools or other safe public places where children naturally spend time. Examples of community settings are:

- Parks
- Restaurants
- Child care centers
- Early childhood education venues
- Schools

Home and community services:

- May be used after discharge from a day services program.
- Provide a developmentally appropriate ABA therapy treatment plan for each child.
- Require recertification of medical necessity through continued authorization.
- Include family or guardian education, support, and training.
- Includes interventions designed to promote the child's generalization and maintenance of new skills and behaviors in a variety of settings through training of the circle of support (e.g. teachers, daycare attendants, other service providers, neighbors, friends).

Note: Provision of services in community settings (e.g. a school or restaurant) must be included in the ABA therapy treatment plan.

What is the early intensive behavioral intervention day treatment program (day treatment program)?

The early intensive behavioral intervention day treatment program (day treatment program) is a short-term day program, that provides comprehensive and intensive services to young children with autism spectrum disorder and related conditions that are amenable to behavioral interventions (empirical support required for related conditions).

The program uses empirically-supported behavioral intervention strategies as the primary mode of treatment. A comprehensive multidisciplinary approach is used, so that additional expertise (e.g., speech therapy) is incorporated into the programming as needed. The philosophy of the program is rooted in principles of ABA.

- The program takes a strengths-based approach to individualizing treatment for each child in order to build skills and reduce challenging behaviors.
- The program incorporates a focus on family support and parent and caregiver education.
- The program uses a positive behavior support framework to address disruptive behavior problems.
- The program serves children ages two through five years who also have a physician's order that they are likely to benefit from a day treatment program.

Purpose of the day treatment program

The purpose of the program is to build an initial foundation for supporting continuity of ongoing care through the assessment of a child's needs and targeting treatment goals that will promote the child's participation in other environments. The program focuses on detailed assessment of learning needs, building learning readiness skills and independence, and providing family and caregiver support and education.

Individualized treatment addresses basic skill areas that support participation in other long-term settings, such as:

- Reduction of challenging behaviors.
- Functional communication skills.
- Adaptive skills, such as toilet training.
- Learning readiness skills, such as attending, understanding of contingency, learning appropriate interactions with play and school materials.

Providers in the day treatment program

WAC 182-531A-0600(3)(a)

Providers rendering direct ABA services must meet the qualifications and applicable licensure or certification requirements as described in the day treatment program model below. Other health care professionals serving as members of the multidisciplinary care team in the day treatment program must be licensed or certified under the chapter of Title 246 WAC that applies to their profession.

Requirements for the day treatment program

Coordination of care. The day treatment program must:

- Coordinate care with additional service providers (such as medication managers and providers conducting medical workup related to the diagnosis of autism and related disorders), if the services are not available within the program.

- Coordinate care with any outside service providers, assuming a release of information has been obtained (e.g., speech language pathology or occupational therapy providers).

- Coordinate care with schools or birth to three (B-3) programs when children are simultaneously receiving behavioral therapy services in these settings. A release of information is required.

- Coordinate advance discharge planning with providers outside the program who will be receiving the child for future services. Coordination with community-based ABA providers, schools, and B-3 programs is particularly important, as children are likely to be returning to care in these settings.

Staffing ratios and planning as follows (see table below):

- Staffing ratio: A 1:1 staffing ratio required. This does not mean every child must have its own TA, but that the overall adult-to-child ratio is 1:1. Programs may have a CBT-to-child ratio of 1:1, but this will depend on what responsibilities other adults (e.g., lead therapist, lead teacher) in the room have.

- Staffing plan: The program must be staffed by at least one LBAT and enough CBTs who meet requirements under WAC 182-531A-0800 to meet the 1:1 staffing ratio.

- Use of trainees as program staff: Students and trainees (e.g., interns, post-doctoral fellows) can be integrated as paid program staff only if they meet the CBT requirements under WAC 182-531A-0800. Otherwise, students and trainees may provide direct care to children in the program as part of a supervised training experience; however, their time must not be billed to the agency.

Program hours, teaching format, supervision, and specialty programs:

- Program hours: Consistent with Washington state B-3 guidelines, children must attend the day treatment program a minimum of three hours per day, for enough days to total a minimum of twelve hours per week, for a total of 48 days. The child must be present for over half of the scheduled daily time in order for the program to bill for that day.

  - ✓ If a program wishes to serve children five days per week, the Medicaid agency covers a maximum of 15 hours per week (three hours per day, five days per week).

  - ✓ The day treatment program typically lasts 12 treatment weeks, or 48 service days.

  - ✓ The Medicaid agency may approve a child to remain in a day treatment program beyond 48 service days in circumstances that may compromise discharge planning (e.g., unresolved serious self-injury or aggression, family crisis, significant safety concerns, etc.).

- Teaching format: The day treatment program must have the capacity to individualize the need for 1:1 versus dyadic or group instruction as needed.

- Supervision: As required under WAC 182-531A-0800, an LBAT must supervise CBTs at a minimum of 5% of all therapy hours provided per week, per child. The LBAT must supervise all aspects of the clinic and remain on-site during all hours the day treatment program is in session.

- Specialty services:

  - ✓ Speech therapy: Speech therapy services must be available to support progress toward meaningful communication goals, as needed.

  - ✓ Parent and caregiver education and training: Parent and caregiver training must occur a minimum of once per week. Goals, format, and number of recommended hours per week should facilitate achievement of treatment goals and be included with the specific, measurable parent goals in the child's individual treatment plan.

Day Treatment Program Model	
Certified Behavior Technicians	Ratio of CBT to child must be 1:1 for all hours the day treatment program is in session (3 hours per day, 4 days per week). CBTs will also need planning, data analysis and supervision time.
Lead Behavior Analysis Therapist	The LBAT must supervise all aspects of the clinic and remain on-site during all hours the day treatment program is in session. LBAT responsibilities include but are not limited to direct supervision of CBTs for a minimum of 5% of therapy hours being provided per week to an individual child.
Speech Therapy	Each child must receive direct, individualized speech therapy with a speech language pathologist (SLP) weekly at a minimum as indicated in the initial assessment.
Parent Training	Parent training must consist of direct individualized training with an LBAT weekly at a minimum. The clinic LBA or LABA will provide parent training. Guest 'parent trainers' may be engaged by the LBAT based on parent's needs (e.g., RN, MD, dentist, social worker, community agency resource person, etc.), including the clinic SLP.
Functional Activities for Daily Living	Common issues seen in children with autism include: sleep disturbances, bed time rituals, elopement, and feeding and meal time challenges. These will all be addressed by the LBAT in development and implementation of the treatment plan.
Coordination of Care	The LBAT will help families access and integrate outside services with clinical services as needed, coordinate discharge and transition services, attend individualized education program (IEP) or individual family service plan (IFSP) meetings, and coordinate with providers in other therapy settings (e.g. school, B-3 programs).

What client files and records does the agency require?

In addition to the documentation required under WAC 182-502-0020, the ABA therapy services provider must keep the following records for each client:

- The prescription or order for ABA Services (if available)
- Any COE evaluations (if available)
- ABA assessments, functional behavior assessments or analysis, and treatment plans
- All collected client data and graphs
- Supervision notes
- Service log documenting that services were provided, dates and times of service, type of service, services provided, and location of where the services were provided
- Notes supporting parenting training, including but not limited to, sign-in sheets if service was provided in a group setting and description of content
- Notes supporting child's participation in group activities and interventions consistent with the treatment plan
- Documentation of coordination of services with other health care providers rendering services to the child or the child's family
- Daily documentation of the child's participation in the program, which must include all the following:

  - ✓ The child's name.
  - ✓ The date of service.
  - ✓ The amount of time the child spent in the program for the day.
  - ✓ Names of clinicians who worked directly with the child.
  - ✓ The goals targeted for the day and strategies used to pursue goals.
  - ✓ The intervention format (for example, individual or group therapy).
  - ✓ Graphed or numeric data that track the child's progress and participation for the day.
  - ✓ The signature, title and credentials of the person completing the daily documentation.

At a minimum, the client's file must contain progress notes that summarize the daily clinical notes. Ideally, the client's file will also include daily clinical notes reporting services provided, including but not limited to, dates and times of service, type of service, services provided, and location of where the services were provided.

Note: Providers who use electronic medical records (EMRs) may summarize hard data to create daily documentation as shown in the example below. Hard data must be maintained in a shadow chart and be available to the agency upon request.

Providers who maintain paper records can set up their daily data sheets to reflect the required information, which will suffice as the day's note.

Example

Name: Susie Smith

Date: 12/12/13

Time statement: 180 minutes

Clinicians: Sally BCBA, LBAT and Donald LABA

Goals targeted/intervention format/treatment strategies and progress:

- Expressive labels targeted during 1-1 DTT instruction (progress: 80% correct response across 3 sets of 10 trials)
- Social initiations targeted during dyadic PRT instruction (progress: 60% correct across 10 prompted trials; 3 spontaneous initiations)
- Imitating symbolic play actions targeted during dyadic PRT instruction (progress: 70% correct across 10 prompted trials; no spontaneous)

Signed: Sally, BCBA, LBAT, Lead Behavior Therapist.

Telemedicine

What is telemedicine?

Telemedicine is when a health care practitioner uses HIPAA-compliant interactive real-time audio and video telecommunications (including web-based applications) to deliver covered services within the practitioner's scope of practice to a client at a site other than the site where the provider is located.

Using telemedicine enables the health care practitioner and the client to interact in real-time communication as if they were having a face-to-face session. Telemedicine allows clients, particularly those in medically underserved areas of the state, improved access to essential health care services that may not otherwise be available without traveling long distances.

Originating site

As it applies to ABA, the originating site is the location of the CBT with the client (for supervision) or the location of the parent (for parent training).

Distant site

A distant site is the physical location where the LBAT is located during the telemedicine session.

Note: If a separately identifiable service for the client is performed on the same day as the telemedicine service, documentation for both services must be clearly and separately identified in the client's medical record.

Which services may be provided via telemedicine?

WAC 182-531A-1200

Telemedicine may be used to provide the following services:

- Program supervision when the child is present.
- Family training, which does not require the child's presence.

The LBA may use telemedicine to supervise the CBT's delivery of ABA services to the client, the family, or both. LBAs who use telemedicine are responsible for determining if telemedicine can be performed without compromising the quality of the parent training, or the outcome of the ABA therapy treatment plan.

> **Note:** While supervision is not a billable service, when telemedicine is used for supervision, providers may bill HCPCs code Q3014 with the CBT's direct service encounter. Providers must have a supervision note written by the supervising LBA in the client's file.

What services are not paid for under telemedicine?

The following services are **not** paid for as telemedicine:

- Email, telephone, and facsimile transmissions.
- Installation or maintenance of any telecommunication devices or systems.
- Purchase, rental, or repair of telemedicine equipment.
- Home health monitoring.

> **Note:** For information on how to bill for telemedicine, see the ABA Treatment fee schedule.

Authorization

WAC 182-531A-1100

What is prior authorization (PA)?

Prior authorization (PA) is the agency's approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement.

The ProviderOne Billing and Resource Guide explains how to check the status of a PA request in ProviderOne. Other resources for PA are available as a training webinar.

Managed care clients must contact their designated managed care organization (MCO) for program requirements.

Providers must submit PA for fee-for-service clients at least fifteen days before they expect services to begin, or before current authorization expires. See WAC 182-501-0165.

When is PA required?

PA is required when:

- The client is a Washington Apple Health fee-for-service client or MCO client enrolled in an MCO that requires PA. Providers should be aware of the PA requirements for each MCO they are contracted with and, if necessary, request PA through the client's MCO.
- The client has a private insurance policy that provides a benefit for ABA services, and that benefit has been exhausted.
- The client has private insurance that does not provide a benefit for ABA services.
- The client has Medicare.

Note: If the client has a private insurance policy that provides a benefit for ABA services and the benefit has not been exhausted, PA is not required. If Washington Apple Health becomes the primary payer (for example, if the private policy's maximum benefit is reached or the parent loses private insurance), the child must go through the agency's case management process, and prior authorization must be obtained for ABA therapy. Parents with private insurance should consider choosing an ABA provider that is enrolled with both the private insurer and Washington Apple Health.

What forms and documents are required for PA for fee-for-service clients?

Providers may submit requests for prior authorization online through direct entry into ProviderOne (See the agency's Prior Authorization webpage for details), or by faxing the following to 866-668-1214:

☐ **A *General Information for Authorization* form HCA 13-835 that is:**
- Typed
- The coversheet for the PA request

☐ **An *ABA Level of Support Requirement* form HCA 12-411**

☐ **An *Assessment and Behavior Change Plan* form HCA 13-400, prepared by the board certified behavior analyst (BCBA), which must include:**
- The LBAT's assessment
- The LBAT's treatment plan, which must include:
  - ✓ The place of service where ABA will be delivered
  - ✓ Anticipated hours of service
  - ✓ Training and specific, measurable goals for the family, the caregiver, or both
  - ✓ The LBAT signature
  - ✓ Signature line for the parent's signature
- The BCBA's functional analysis, if one was completed.

☐ **A copy of a signed prescription for ABA therapy services, if available, with initial PA**

☐ **A copy of the COE evaluation, if available, with initial PA**

For information about downloading agency forms, see Where can I download agency forms?

Does PA for ABA services expire?

WAC 182-531A-1100

Yes. The agency grants authorization in three to six-month increments, or longer at the agency's discretion. Three weeks before the expiration date of the current authorization, the LBAT must recertify authorization to continue services. Check with the MCO for their policy on expiration of PA.

For information on how to request continuation of ABA services, see What are the requirements for recertification of ABA services?

What if additional units of service are needed to continue providing ABA services?

WAC 182-531A-1100

If during a particular PA period, the child's condition changes and additional units of service are needed to continue providing ABA services, the LBAT must request PA for additional units.

To request authorization for additional units for FFS clients, follow these steps:

1. Open the agency's document submission cover sheet *PA Pend Form*.
2. Enter the 9-digit authorization reference number from the agency's authorization letter; hit return to generate a barcode.
3. Click "Print Cover Sheet"
4. Fax the *PA Pend Form* and supporting documents to 1-866-668-1214. Use the *PA Pend Form* with its unique bar code as the first page of your fax.

> **Note:** Do not submit requests for authorization of additional units as a new request.

For clients who are enrolled in an agency-contracted MCO, follow the guidelines of the MCO for additional units.

What are the requirements for recertification of ABA services?

WAC 182-531A-1100

Continued ABA services require the agency's or MCO's PA. The following are requirements for recertification of ABA services:

- The LBAT must submit a new request for authorization to continue services at least three weeks before the current authorization expires. (See the agency's Prior Authorization webpage for details)

- The LBAT must submit a reevaluation and revised ABA treatment plan that documents the client's progress, showing measurable changes in the frequency, intensity, and duration of the targeted behavior or symptoms addressed in the previously authorized ABA treatment plan. Documentation must include all of the following:

  - ✓ Projection of eventual outcome.
  - ✓ Assessment instruments.
  - ✓ Developmental markers of readiness.
  - ✓ Evidence of coordination with providers.

Additional requirements for recertification of ABA services

When deciding whether to authorize continued ABA services, the agency may request a review and recommendation by the evaluating and prescribing COE provider.

In these cases, the COE provider must review the ABA treatment data, conduct a face-to-face visit, facilitate a multidisciplinary record review of the client's progress, hold a parent conference, or request a second opinion before recommending continued ABA services. Providers must continue services pending recertification.

Why might the agency deny recertification of ABA services?

WAC 182-531A-1100 (5)

The basis for denial of services includes but is not limited to the following:

- Lack of medical necessity. For example:
  - ✓ The child fails to respond to ABA services, even after encountering different ABA techniques and approaches, if applicable.
  - ✓ There are no meaningful, measurable, functional improvement changes, or progress has plateaued, without documentation of significant interfering events (e.g., serious physical illness, major family disruption, change of residence), if applicable. For changes to be meaningful, they must be all of the following:
    - ➢ Confirmed through data.
    - ➢ Documented in charts and graphs.
    - ➢ Durable over time beyond the end of the actual treatment session.
    - ➢ Generalizable outside of the treatment setting to the client's residence and the larger community within which the client resides.
- Noncompliance (e.g., failure to keep appointments, parent fails to attend all treatment sessions, parent fails to attend scheduled parent training sessions), if applicable.

What is a limitation extension (LE)?

WAC 182-501-0169

A limitation extension (LE) is the agency's authorization for a provider to furnish more units of service than are allowed in Washington Administrative Code (WAC) and this guide. The provider must provide justification that the additional units of service are medically necessary.

Examples of additional services for which a provider might request an LE include:

- Behavior identification assessment, treatment plan development (97151).
- Exposure behavioral follow-up assessment (0362T).

Note: LEs do not override the client's eligibility or program limitations.

How do I obtain an LE?

Providers may obtain authorization for an LE request online through direct entry into ProviderOne (see the agency's Prior Authorization webpage for details).

If the provider choses to request an LE by fax to 866-668-1214, all of the following documentation must be submitted:

- **A completed, typed *General Information for Authorization* form (HCA 13-835)** (See Where can I download agency forms?). The form must be the coversheet for the PA request and include:

  ✓ Additional units of service needed
  ✓ Supporting justification of medical necessity

- **Description of services provided and outcomes obtained in treatment to date**

- **Expected outcome of extended services**

Coverage

WAC 182-531A-0900

What is covered?

The agency covers the following services only in the settings indicated for eligible clients by recognized ABA providers.

ABA treatment – home and community-based settings

ABA Treatment Codes

Procedure Code	Short Description	PA?	Comments
Functional Assessment and Analysis/Treatment Plan Development			
97151	Behavior identification assessment;		LBAT 15 minute unit 28 units per assessment, 2 assessments per year
0362T	Functional analysis for severe maladaptive behavior in specific setting;		LBAT and 2 or more CBT's 15 minute unit bb
Telemedicine			
Q3014	Telehealth originating site facility fee		Per complete transmission
Team Conference			
99366	Team case conference		With client and/or family, face to face, 30 minutes or more
99368	Team case conference		Without client or family, face to face, 30 minutes or more
Individual Treatment Codes			
97153	Adaptive behavior treatment by protocol	Yes	CBT , 15 minute units
0373T	Adaptive behavior treatment with protocol modification		15 minute unit, LBAT and 2 or more CBT's client exhibits destructive behavior, provided in a customized environment
97155	Adaptive behavior treatment with protocol modification		15 minute unit LBAT and possible CBT

Procedure Code	Short Description	PA?	Comments
Caregiver/Parent Treatment Codes			
97156	Family adaptive behavior guidance		15 minute unit LBAT
97157	Multiple – family group adaptive behavior treatment guidance		15 minute unit LBAT, two or more caregivers/families
ABA Group Home and Community Based Treatment			
97154	Group adaptive behavior treatment by protocol	Yes	15 minute unit Two or more clients
97158	Group adaptive behavior treatment with protocol modification		15 minute unit LBAT
ABA Intensive Day Treatment			
H2020	Therapeutic behavioral services per diem	Yes	Per diem

*** Note:** Use XE modifier when providing two distinct and different services in one day, e.g., team conference 99366 XE and parent training 0370T.

ABA treatment – group settings

Procedure Code	Modifier	Short Description	PA?	Comments
Parent Training in a Group Setting*				
97157	UN	Parent training – 2 families		Per 15 min
	UP	Parent training – 3 families		Per 15 min
	UQ	Parent training – 4 families		Per 15 min
	UR	Parent training – 5 families		Per 15 min
	US	Parent training – 6+ families		Per 15 min
ABA Group Treatment in Home and Community-Based Settings*				
97154/97158	UN	Skills train and devel – 2 clients	PA	Per 15 min
	UP	Skills train and devel – 3 clients	PA	Per 15 min
	UQ	Skills train and devel – 4 clients	PA	Per 15 min
	UR	Skills train and devel – 5 clients	PA	Per 15 min
	US	Skills train and devel – 6+ clients	PA	Per 15 min

* Group fees are included to illustrate the use of modifiers. Providers must bill per client.

For additional information about the ABA code changes see the Adaptive Behavior Assessment and Treatment Code Conversion Table at the Behavior Analyst Certification Board website.

What modifiers do providers bill with?

When providing two distinct services on the same day for the same client, the **XE modifier** must be used to distinguish them as distinct and occurring during a separate encounter. For example, use CPT 99366 or 99368 on the same day as CPT codes 97156 or 97157.

When services are provided in a group setting, providers must add the following modifiers to CPT codes 97154/97158 and 97156/97157:

- UN: Two clients or families
- UP: Three clients or families
- UQ: Four clients or families
- UR: Five clients or families
- US: Six or more clients or families

What about services covered under other agency programs?

The agency covers many other services that may be provided in conjunction with ABA services. Examples of these programs include:

- Mental Health Services
- Dental Services
- Early Periodic Screening, Diagnosis and Treatment (EPSDT)
- School-Based Health Care Services
- Neurodevelopmental Centers
- Nondurable Medical Supplies & Equipment (MSE)
- Outpatient Rehabilitation
- Prosthetic & Orthotic Devices
- Wheelchairs, Durable Medical Equipment (DME), and Supplies
- Speech, Occupational, and Physical Therapy

Note: The agency does not authorize ABA services if the services are duplicative of services being provided in another setting, or paid for by another state agency. See WAC 182-531A-0900(3).

Which services are not covered?

WAC 182-531A-1000

The agency does not cover the following services (this list is not exhaustive):

- Autism camps
- Dolphin therapy
- Equine or Hippo therapy
- Primarily educational services
- Recreational therapy
- Respite care
- Safety monitoring services
- School-based health care services or early intervention program-based services under WAC 182-531A-0600 (3)(b)(iii), unless prior authorized
- Vocational rehabilitation
- Life coaching
- Treatment that is unproven or investigational, (e.g., holding therapy, Higashi, auditory integration therapy, etc.)

Billing

All claims must be submitted electronically to the agency, except under limited circumstances. For more information about this policy change, see Paperless Billing at HCA.
For providers approved to bill paper claims, see the agency's Paper Claim Billing Resource.

What are the general billing requirements?

Providers must follow the billing requirements listed in the agency's ProviderOne Billing and Resource Guide. The guide explains how to complete electronic claims.

- Providers must provide the authorization number on both the institutional and professional claims.
- The dates of service, procedure codes, modifiers, and units of service must match those authorized on the authorization record to be paid.
- The taxonomy used on the claim submitted to the agency must be loaded on the ProviderOne provider's file.

What procedure codes do I use to bill for home and community-based services?

Refer to the agency's Fee Schedule for the procedure codes and modifiers assigned to this program. Be sure to use the correct fee schedule for the dates of service billed.

For example: one hour of adaptive behavior therapy provided on 12/31/2018 is billed with one unit 0364T and one unit 0365T. The same service provided on 01/03/2019 would be billed four units 97153.

What codes do day treatment programs use to bill the agency?

Day treatment programs operating in a clinic setting use an electronic professional claim to bill HCPCS code H2020.

Day treatment programs that bill as an outpatient hospital are able to use an electronic institutional claim. When preparing the claim, the revenue code assigned to this program is 0509 and the procedure code assigned to this program is H2020. Refer to the agency's Fee Schedule.

Hospital outpatient providers may access instructions on completing and submitting claims using the ProviderOne Billing and Resource Guide.

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the agency's Billers and Providers webpage, under Webinars.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the HIPAA Electronic Data Interchange (EDI) webpage.

Rendering and individual provider taxonomy numbers

The only applicable taxonomy number for ABA therapy services is 103K00000X. All rendering and individual providers must use this taxonomy for enrolling and billing. This taxonomy code must be entered into both the billing and servicing taxonomy fields on the electronic professional claim.

Note: The rendering provider is the servicing or performing provider.