

Applied Behavior Analysis Agency Manual Instructions

Thank you for your interest in becoming a New Mexico Human Services Department (HSD) Medical Assistance Division (MAD) Applied Behavior Analysis Provider (AP) agency! Detailed in this document are the requirements, considerations, suggestions to design your agency's Applied Behavior Analysis (ABA) Stage 2 and 3 Manual. The ABA Manager is here to assist you in completing a manual and then approving it. You are welcomed to share portions of the manual with the manager or wait and submit the complete document. For each age group (see Checklist), a mock or redacted file must be submitted. For ease of sharing comments, please submit your manual as a Word document. Recipient files may be in word or a PDF. Please contact Annabelle Martinez at AnnabelleM.Martinez@state.nm.us to receive the draft supplement in a Word document.

Please think of this process as the vehicle to implement high quality ABA services. It is MAD's expectation the manual you submit for review includes all required elements AND that it is tailored for your agency. MAD further expects you will use the manual as a training guide and to refresh staff's understanding how your agency delivers ABA services. What generally causes billing issues and recoupment is when the agency has what is called *Mission Drift*. This occurs when staff train other staff that then those staff train other staff. All it takes is one staff to miss critical information or steps for a cascade of questionable rendering and billing of services. Therefore, MAD requires the agency to implement an ABA service evaluation. Some have built in specific times in their operating year to revisit with staff their manual to ensure continued compliance. There are times when MAD provides new directions and instructions through an amendment to its New Mexico Administrative Code (NMAC) rules (administrative law), Behavioral Health Policy and Billing Manual (BH Manual), and supplements where that information must be timely shared with staff.

MAD also requires ongoing supervision and evaluations of practitioners. As the two practice boards require supervision specific to their certificate holders, these are not reimbursable services. MAD does reimburse case supervision and clinical management specific to the recipient. MAD encourages the agency to include these two types of supervision documents in the practitioner's overall evaluation so that the practitioner can build on their success for the overall benefit of the recipients.

Attached is the ABA draft Section which you will most likely be operating under by the time your manual is approved, and your agency is credentialed by a Centennial Care Managed Care Organization (MCO). Embedded in each subsection are detailed billing instructions. MAD cannot stress enough a thorough reading of the draft Section to then counter check against your manual for completion. Often an agency begins designing its manual and only generally reviews the section. This leads to delayed times in the approval process. The draft Section is written in such a way that an agency could copy and paste and modify to their specific operations if so desired.

Reference Terms

A **recipient** is an individual who has a Medical Assistance Programs (MAP) category of eligibility. A recipient may be a **member** of a MCO, though not every recipient is a member of a MCO. There are some recipients who meet the requirements to use what is called the Fee-for-Service (FFS) benefit package. These are Native Americans who do not meet a nursing level of care. The benefits for ABA are the same, however, a MCO may offer additional benefits not included in the FFS benefit package unrelated to ABA services.

Early, Periodic Screening, Diagnostic and Treatment (EPSDT) program provides services that are specific to recipients between birth up to 21 years of age.

Adult recipient is 21 years and older. They have in addition to standard ABA services, specifically designed services, and tiered reimbursements from EPSDT-aged recipient.

Behavior Analyst includes: a Behavior Analyst Certification Board (BACB) recognized Qualifying Psychologist who is licensed as a psychologist in New Mexico; a BACB Board Certified Behavior Analyst (BCBA) Doctorate (BCBA-D); and a BACB BCBA.

Board Certified Assistant Behavior Analyst (BCaBA) is referred to in one of two ways for MAD: a Behavior Assistant Analyst (**BAA**) is a BCaBA, and a Supervising BAA is a BCaBA who has successfully completed BACB supervisory training.

Behavior Technician (BT) includes:

- (a) BACB Registered Behavior Technician;
- (b) Behavioral Intervention Certification Council (BICC) Board Certified Autism Technician (BCAT);
- (c) non-certified behavior technician (time limited). There are services a RBT and BCAT may render that are not supported by a non-certified BT. In such situations, directions and instructions are clearly detailed in the draft billing instructions.

The **Centers for Medicare and Medicaid Services (CMS) Unlikely Medical Events (MUEs)** provide instructions to state Medicaid programs the unit limits a specific code/service may be rendered daily. MAD in several codes/services, follows CMS MUE limits. However, MAD under strict guidance is allowing specific codes/services to be rendered more than the MUE limit. See the billing instructions found in draft Section for allowances and restrictions for exceeding MUE limits.

Unique Aspects of MAD ABA Services

ABA is comprised of three stages: evaluation, assessment, and implementation of services. Stage 1 and Stage 2 services are not prior authorized; however, the billing piece of Stage 1 and Stage 2 services does have unit limits. These services may be rendered without prior authorization whenever the AEP or BA determines the medical necessarily. For Stage 3 services, some services require prior authorization, while others do not. Refer to the draft Section billing instruction for each code.

Stage 1 services are the initial process for accessing ABA services. MAD enrolls Autism Evaluation Practitioners (AEPs) to complete one of three types of evaluations.

Comprehensive Diagnosis Evaluation – an EPSDT-aged recipient between 12 months up to 21 years of age is required to complete at least one CDE within specific timeframes.

Targeted Evaluation –

- (a) an EPSDT-aged recipient whose current presentation is markedly different than at the time of the CDE, may have a Targeted Evaluation homing in on specific aspects of concern;
- (b) an adult recipient is not required to complete a CDE; instead, a Targeted Evaluation is conducted within specific timeframes.

Risk Evaluation – an EPSDT-aged recipient 12 months up to three years who meets the At-Risk criteria, their evaluation is focused on determining if there is a high probability within this timeframe a diagnosis of ASD will be rendered. MAD supports early and timely intervention services.

- ❖ When a CDE or Targeted Evaluation is completed, an Integrated Service Plan (ISP) or for Risk Evaluation, a Risk Report with ISP embedded within, must be completed at the initial evaluation and thereafter whenever a new evaluation is completed.

- ❖ An AEP may determine the recipient requires only an updating of their ISP and a new evaluation is not medically necessary. The AEP then completes an ISP Update.

Family Set includes members of the recipient's family and care network who together provides support for the goals the recipient is working towards. The BA and recipient, and guardians determine the composition of the Family Set. Each recipient's Family Set differs from another's. Such examples include but are not limited to: an adult recipient who resides in an assisted living arrangement, the facility staff may be included; a recipient using their Developmental Disabilities Waiver services, a Behavioral Support Consultant may be included.

ABA Adult Tiered Services are designed to support an adult the length of their life as they navigate through changes in supports, housing, employment, sicknesses, death of Family Set members.

Maintenance Services are designed to support the recipient with regular and consistent services to remain successfully in their home and community.

Intervention Services are designed to provide additional supports when the adult recipient's normal life routine is disrupted by events. The intent of the increased units is the adult recipient stabilizes and moves back to Maintenance Services and does not require a higher tier intervention.

High-Risk Intervention Services are designed to provide high levels of intervention services to support an adult recipient who is experiencing events or behaviors that are destructive or self-injurious or injurious to others. The intent of the increased units is the adult recipient does not require institutional services or incarceration and moves either back to Intervention level of services or Maintenance Services.

Telehealth includes three means of delivering a service to a recipient when not rendered in person. Check each service's billing instructions to determine which can be delivered through Telehealth.

Telemedicine is real time audio and video between the location of the recipient (originating site) and the location of the practitioner (distant site). For 97156 and 97157, MAD allows the use of telemedicine to deliver guidance to members of the Family Set. Think of this as a Zoom-like meeting where different Family Set members of the recipient are in different locations all participating in the session. This applies to multiple Family Sets (97157) joining each other in a virtual meeting. MAD encourages AP agencies to use this delivery system to meet the needs of Family Set members who cannot attend during regular business hours groups. A parent who travels for work, could easily keep engaged by participating in 97156 during their lunch or dinner time.

Telephonic is the use of a telephone or cell phone to render services in real time with only audio. Currently only under an Emergency Order from the Governor may some services be rendered telephonically. A MAD supplement is issued informing providers and practitioners of the Emergency Order and codes allowed to be rendered telephonically.

Store and Forward Technology is when the originating site practitioner records in real time audio and video a service and then transmits the image to a distant site practitioner. In New Mexico, recipients are in areas where there is no Internet, so telemedicine delivered services cannot be rendered. For Case Supervision, MAD allows a BT or BAA to video a session, store the video and sent to the BA or Supervising BAA for both practitioners to later review and plan for the next intervention with the recipient.

ABA Grace Period Exceptions are allowed until such time as a recipient can schedule and complete Stage 1 services in a timely manner that supports them entering services quickly.

1. For an EPSDT-aged recipient who has been diagnosed with ASD by a MAD approved Grace Period Practitioner and has a scheduled appointment for a CDE or Risk Evaluation, Stage 2, and once approved, Stage 3 services may continue until the CDE or Risk Evaluation is completed and a diagnosis of ASD is either rendered by the AEP or ruled out. See draft **Section 3.2.3.B(2)(a-b)**.
2. Adult recipients have three Grace Period Exceptions; see draft **Section 3.2.3.B(2)(a)** and **3.2.3B(3)(a-b)**.

Stage 2 services focus on the BA assessing the recipient's presentation and developing a treatment plan for the recipient. The recipient or guardian provides the AP agency a copy of:

- (a) completed CDE/Risk Evaluation with ISP and a diagnosis of ASD; or
- (b) completed Targeted Evaluation with ISP for adults; or
- (c) Grace Period Diagnosis of ASD (see **Section 3.2.3(B)(a)**).

Once the recipient is scheduled for an assessment, their Family Set members may access Stage 3 services of 97156 and 97157 until such time as Stage 3 services are prior authorized and started.

After the AP agency has accepted the recipient into Stage 2 services, the BA renders themselves or through a BAA or BT a behavior, and if medically warranted, a functional assessment. The BA develops a treatment plan, engaging the recipient or guardian and other Family Set members. Using New Mexico's standardized prior authorization request form, submits the treatment plan, the most current CDE, Targeted, or Risk Evaluation and submits to the recipient's MCO or if the recipient is using their FFS benefit package, submits to Comagine, MAD's third party assessor. Please see MAD Supplement 20-01 for detailed information concerning prior authorization, link below.

<https://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/Supplements%20for%20MAD%20NMAC%20Program%20Rules/SUPPLEMENT%2020-01.pdf>

There are three codes for Stage 2 services.

- ❖ **97151** is rendered by the BA. This includes the development of the treatment plan and submission of the prior authorization.
- ❖ **97152** is rendered by one BAA or BT, under the direction of a BA.
- ❖ **0362T** is rendered by two or more BAs/BAA's/BT's on behalf of a BA or Specialty Care Practitioner (SCP), (discussed towards the end of this document) with the BA or SCP immediately available onsite. A SCP does not bill **97151** or **97152**; instead bills **0373T**.

Stage 3 Services – Case Supervision and Clinical Management

MAD requires a BA or Supervising BAA to conduct **T1026 UD Clinical Management** services at a preset ratio, see draft **Section 3.4.2.A**. Clinical management supports a BA and Supervising BAA reviews of graphs, observations from **T1026 UD Direct Case Supervision and Indirect Case Supervision** and other reports from the BAAs and BTs and from this information, may modify a recipient's protocols and goals.

MAD requires a BA or Supervising BAA to meet with the recipient's BAAs and BTs to discuss the modifications of the protocols. If the protocols require training outside their practice boards' training and are unique to that recipient, a BA or Supervising BAA may be reimbursed for such services.

A **Mentored BA** has the same responsibilities as a BA. MAD reimburses mentorship services to support a new BCBA develop the skills for treat higher need and complex recipients. A BA may conduct Case Supervision with a Mentored BA separately to facilitate the practitioner's skill development specific to the recipient's needs.

Stage 3 Services Implementation of Treatment Plan

The following services do not require prior authorization. They are included a part of the prior authorization to demonstrate the cohesive plan for the recipient.

T1026 of any ABA modifier

97154

97155

97156

97157

97158.

Specialty Care Services are designed to assist a recipient who is experiencing or demonstrating behaviors for which the AP agency's BA staff require assistance from a highly trained BA: a Specialty Care Practitioner. BACB provides the requirements of training, education, and experience to be recognized as a Specialty Care Practitioner. Specialty Care services may be rendered alongside the recipients ABA treatment plan or if the recipient's team determines the medical necessity for only the Specialty Care Treatment Plan to be rendered. See draft **Section 6.A** for detailed description of a SCP's requirements and the currently recognized Specialty Care areas.

MAD ABA Stage 2 and 3 Services Requirements for the Applying Autism Provider (AP) Agency

Purpose of Manual: The approved Autism Provider Agency manual serves to provide practitioners and supervisors of MAD ABA Stage 2 and 3 services the requirements each must comply with and concrete process to deliver these services. It is MAD's expectation that the manual is used as a training for new practitioners and as ongoing direction

Please review the current and draft of the Behavioral Health Policy and Billing Manual (Manual) Section 3 to incorporate into your agency's ABA Manual to be used by the agency staff and practitioners. Below are the elements MAD is requiring the inclusion in your ABA manual. Please send a request for the draft or if released revised Manual by emailing JenniferL.Chavez1@state.nm.us. Please send your manual in a Word document for review and comments.

Part I Agency Narrative Documents

Note: Agency may already have these in the organization's overall policies and procedures. If so, please include a copy.

- Provide a description of the agency used to inform a new employee of the agency's mission statement, history, management structure, legal structure and ownership, location(s)
- If there are multiple sites, provide a description of the sites and how sites communicate between each other.
- Provide a program organization chart specific and drilled down to include all ABA positions.
- Describe for employees the agency's record keeping practices at main office and other sites when applicable. This includes flow chart of process, how intake and treatment information is stored and secured, how PHI is transferred outside a clinic setting.
- Provide ABA practitioner job descriptions. Look at the draft Section for each practitioner's requirements. An agency may include additional requirements. Do not submit at this point practitioner licenses or certifications.
- Provide copy of agency employee performance process and evaluation tool that incorporates:
 - Summary of Case Supervision records for all practitioner's recipients; and
 - Summary of the practitioner's BACB and BICC boards' supervision notes and follow-ups.
- Provide copy of case supervision form used for T1026 UD Direct and Indirect Case Supervision and the BACB or BICC supervision requirements.
- Provide copy of initial and concurrent treatment plan process and form(s). This may be included in the mock files submitted.
- Provide copy of program evaluation form specific to determining if ABA services are meeting the needs of recipient and families, practitioners and funding sources. This may include times between referral, to assessments, and then for treatment. There must be a summary of annual findings and process for self-correction.
- Information as to which assessment/diagnostic evaluation tools agency is using.

- Provide copy of medication form if applicable.

Part 2 Applied Behavior Analysis Program - Policies and Procedures

Please review the BH Manual Section 3 or the draft Manual to ensure responses are specific to MAD ABA. Within the Manual are processes and requirements already detailed. Remember, this is the training and resource guide for practitioners and supervisors of what, when and how services are rendered, documented and reimbursed.

Describe the agency's intake process and how recipients are assessed for eligibility. This should be a step by step process, not an overview.

Describe how treatment planning is related to the Stage 1 diagnostic evaluation (CDE or Targeted or Risk Evaluations), the Integrated Service Plan (ISP), and recommendations for ABA Stage 2 and 3 services. This should be detailed in the assessment summary and for the prior authorization request for services to the MCO or Third Party Assessor (TPA).

Describe how agency determines a recipient receives home-based or clinic services.

Describe how a recipient moves out of ABA Stage 3 services.

Describe how the agency supports the practitioner to incorporate a recipient's unique resiliency values, cultural sensitivity, and gender-informed care.

Describe how the agency expects its practitioners to provide crisis management including the crisis/safety planning process for staff and recipients.

Describe how the agency determines its waitlist keeping in mind EPSDT-aged recipients 12 months to 3 years are prioritized for services.

Part 3 ABA Program Structure - Policies and Procedures

When an agency is only offering clinic-based or home-based services, describe how the agency meets newly recognized needs of a recipient who requires a different place (such as from home to center). Will the recipient be transferred to a new agency?

When an agency is only offering services to a specific age, describe how the agency informs the recipient or family, incorporates into its treatment plan transition activities to another agency. It is critical the agency determine beforehand the age ranges it will serve and the parent's agreement prior to the start of services and transition plans are ongoing as the recipient ages toward the agency's cut off age.

Describe how a practitioner checks out equipment and materials for home or center use. Is there a fund or lead/lease process to assist parents or recipients acquire these on their own?

Provide policy and procedure that clearly outlines ABA practices are utilized and how this model will be evaluated according to fidelity standards.

Describe how deficiencies will be addressed. Include process for assessing treatment/program outcomes.

Provide policy and procedure that specifically supports parent guidance to ensure ABA practices are learned and generalized in a community setting.

Part 4 Supervision of Staff - Policies and Procedures

Home-based services Provide policy and procedure that specifies how the agency assesses supervisory requirements for clinical management and case supervision.

Clinic-based services.

Provide policy and procedure that specifies how the agency assesses supervisory requirements for clinical management and case supervision.

Home-based services Include how supervision is provided to include frequency, number of hours, how this is documented. Include information on how deficits in training/practice are identified and addressed in a time-limited manner for both the supervisor and the supervisee. Remember, MAD only reimburses for training that is specific to the recipient, not part of their certification requirements.

Clinic-based services.

Include how supervision is provided to include frequency, number of hours, how this is documented. Include information on how deficits in training/practice are identified and addressed in a time-limited manner for both the supervisor and the supervisee. Remember, MAD only reimburses for training that is specific to the recipient, not part of their certification requirements.

Home-based services Include how supervision is provided to include frequency, number of hours, how this is documented. Include information on how deficits in training/practice are identified and addressed in a time-limited manner for both the supervisor and the supervisee. Remember, MAD only reimburses for training that is specific to the recipient, not part of their certification requirements.

Clinic-based services.

Include how supervision is provided to include frequency, number of hours, how this is documented. Include information on how deficits in training/practice are identified and addressed in a time-limited manner for both the supervisor and the supervisee. Remember, MAD only reimburses for training that is specific to the recipient, not part of their certification requirements.



Part 5 Program specific and agency training - Policies and Procedures

Home-based services Provide policy and procedure that clearly outlines the process for ensuring that all ABA treatment staff has been adequately trained. Describe how staff will receive ongoing training as needed and how skill level of trainers is evaluated. Remember, MAD only reimburses for training that is specific to the recipient, not part of their certification requirements.

Clinic-based services Provide policy and procedure that clearly outlines the process for ensuring that all ABA treatment staff have been adequately trained. Describe how staff will receive ongoing training as needed and how skill level of trainers is evaluated. Remember, MAD only reimburses for training that is specific to the recipient, not part of their certification requirements.

Provide policy and procedure that describes how program staff are trained in culturally sensitive and crisis management and safety techniques, critical incident reporting, HIPAA, agency records management and record keeping protocols, and ethics to include conflict of interest.

Provide policy and procedure to demonstrate compliance with New Mexico Children’s Code NMSA 1978 32A-1-1 et Seq statutes and associated New Mexico Children’s Code definitions. Specifically: Mandatory Child Abuse and Neglect reporting

Children's Rights and age-specific Consent for Services statutes.

Part 6 Staff Documents

Provide policy and procedure to demonstrate compliance with background checks for all employees.

Provide policy and procedure to explain how treatment is developmentally appropriate (for all ages served) and is youth and family or adult centric.

Part 7: Mock File

One or more mock files must be submitted as part of the review process. The file(s) must reflect the policies and procedures, and be inclusive of the forms and reports, noted in the aforementioned sections. If the agency delivers services to recipients of varying ages, a mock file must be provided for each age category. This will allow the reviewer to evaluate how the agency tailors service design and delivery to meet the unique needs of recipients of different age groups.

- A mock file representing services rendered to an EPSDT-aged recipient 12 months up to 3 years who is at-risk for the development of ASD.
- A mock file representing services rendered to a EPSDT-aged recipient 12 months through 5 years of age with a diagnosis of ASD.
- A mock file representing services rendered to an EPSDT-aged school aged recipient (kindergarten up to age 18 years) with a diagnosis of ASD.
- A mock file representing services rendered to an EPSDT-aged recipient between the ages of 18 up to 21 years) with a diagnosis of ASD.
- A mock file representing services rendered to an adult (21 and older) recipient with a diagnosis of ASD.

This document pages 10-75 are in **DRAFT form. It is to be used as a guide until a MAD Supplement is issued. At that time, pages 10-75 will end and new applying providers will use that Supplement.**

APPLIED BEHAVIOR ANALYSIS (ABA)

1. Overview

Autism Spectrum Disorder (ASD) is a neurodevelopmental disorder as defined by the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD). ASD is a life-long disorder and as such requires ongoing supports and services. Discharge occurs when the eligible recipient no longer is diagnosed with ASD, elects to end ABA services, or fails to fulfill their responsibilities of being actively engaged for ABA services. Once diagnosed with ASD, an eligible recipient discharge from ABA services to later re-enter services. The Autism Provider (AP) agency must begin ABA Stage 2 services, unless ABA Stage 1 services are medically warranted.

Applied Behavior Analysis (ABA) are techniques and principles used to bring meaningful and positive changes in behaviors. ABA is the science in which the principles of the analysis of behavior are applied systematically to improve socially significant behavior and experimentation is used to identify the variables responsible for behavior change.

The term eligible recipient is inclusive of a member of a Human Services Department (HSD) Centennial Care managed care organization (MCO). However, a member of a MCO may have additional services. The term member is used when this is the case. Eligible recipient covers the range of age from 12 months and older. If a service is specific to an EPSDT-aged (12-months to 21 years) or to an adult eligible recipient (over 21 years), the supplement will note the age range.

The Medical Assistance Division (MAD) pays for medically necessary, empirically supported, Applied Behavior Analysis (ABA) services for eligible recipients 12 months and older who have a documented medical diagnosis of Autism Spectrum Disorder (ASD), or meet the At-Risk Criteria, or are eligible for the MAD Early, Periodic Screening, Diagnostic and Treatment (EPSDT) or Adult ABA Grace Exception. ABA is an EPSDT service from 12 months up to 21 years and for adults 21 years and older. ABA services are provided to an eligible recipient as part of a multi-stage comprehensive approach consisting of evaluation, assessment, and treatment which stipulates that ABA services be provided in coordination and simultaneously with other medically necessary services (e.g., Department of Health Family Infant Toddler program services (FIT), occupational therapy, speech language therapy, behavioral health treatment, medication management, day habilitation, out-of-home placements, medical or dental care practitioners, MAD waiver services). MAD further offers specialty care services for an eligible recipient who meets one or more of the ABA Specialty Care Areas. The information provided to the eligible recipient's and members of their Family Set must be culturally responsive and understandable.

1.1 Family

. A Family Set includes all individuals who are assisting the in the eligible recipient's care, such as, but not limited to: the eligible recipient's family and caregiver, IFSP or IEP staff, specialized service providers, such as PSR, BMS, day habilitation, vocational or education staff, respite providers, treating primary or specialty care providers (such as occupational therapist) residential or institutional care staff such as when the eligible recipient is residing in an ARTC/RTC/TFC, assisted or supportive living.

Quality ABA services are complex and require highly trained practitioners to evaluate, assess and deliver services. Requirements of the utilization are:

- ABA Stage 1 Autism Evaluation Practitioners (AEP)s.
- ABA Stage 2 Behavior Analyst Certification Board (BACB) Qualified Psychologist and Board-Certified Behavior Analysts (BCBA and BCBA-Ds), or Mentored BCBA.
- ABA Stage 3 services include Stage 2 practitioners as well as BACB Registered Behavior Technician (RBTs), Behavioral Intervention Certification Council (BICC) Board Certified Autism Interventionist (BCAT) and non-certified behavioral technicians.
- Specialty Care Practitioners require additional training, education, and experience in addition to a Qualified Psychologist and BCBA.

1.2 A MCO or MAD's Third-Party Assessor (TPA) must employ or contract with a BCBA or BCBA-D to review initial and continuing prior authorization requests for ABA Stage 3 prior authorized services or for any MCO appeals and HSD administrative hearings for denied ABA Stage 1-3 services and claims.

1.3 A Service Authorization (Stage 2 and 3): The purpose of the Service Authorization is to implement a series of interventions over a set number of years by decreasing maladaptive behaviors and promoting appropriate behaviors over the eligible recipient's Service Authorization period. As many recipients with ASD have a number of concerns, unless the eligible recipient does not require a higher level of care, continues to be diagnosed with ASD, or does not meet the conditions for termination of services, the recipient remains in ABA Stage 3 services. MAD has an expectation ABA services will be medically necessary throughout the eligible recipient's lifespan in varying intensity. An updated ISP is needed:

- For an EPSDT-aged eligible recipient 12 months up to eight years, their Service Authorization is three years.
- For an EPSDT-aged eligible recipient eight years and older, their Service Authorized is six-years.

1.3.B Prior Authorization Period (Stage 2 and 3): The purpose of the Prior Authorization is to ensure the recipient's treatment plan for 97153 services is appropriate in light of the current presentation based on the submitted six-month report. Again, a recipient continues to access ABA services unless one of these situations occurs. A MCO or TPA cannot deny a Service Authorization and continuing Prior Authorization if the recipient continues to be diagnosed with ASD and either is able to maintain their current presentation with support through ABA services or improves in deficient areas. As ASD is a lifelong diagnosis, supports through ABA services are medically necessary throughout the eligible recipient's lifespan in varying intensity.

- For an EPSDT-aged eligible recipient between 12 months to eight years, the Prior Authorizations for **97153** or **0373T** are every six months during the Service Authorization period.
- For an eligible recipient eight years and older, the Prior Authorizations for **97153** or **0373T** are annually during the Service Authorization.

1.3.C. During the MCO or TPA initial and continuing review of the eligible recipient's Prior Authorization request, they shall not deny ABA Stage 3 services based on the eligible recipient no longer meeting the criteria for ABA services unless:

1. The AEP conducts a new CDE (T1026 TG), Targeted or Risk Evaluation (T1026 HK); or
2. The Grace Period Practitioner conducts another evaluation
3. To determine if the eligible recipient's:
 - i. AEP or Grace Period Practitioner no longer determines the eligible recipient can be diagnosed with ASD and no longer recommends ABA services.
 - ii. The AEP or Grace Period Practitioner recommends a higher level of care.

1.4 ABA Services Delivered Via Telemedicine

Telemedicine is not a service as such; it is the way an approved service is delivered. The use of telemedicine delivered ABA Stage 1 through 3 services is appropriate at all the same locations as other face-to-face services. MAD pays for telemedicine communication system per recipient/per service for the delivery of ABA services. See 8.310.2 NMAC for a detailed description of telemedicine requirements. [https://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20310/8_310_2%20Revised\(1\).pdf](https://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20310/8_310_2%20Revised(1).pdf)

See subsections of this supplement for detailed description of each CPT or HCPCS code as to who may deliver the service via telemedicine and under what situations the **Q3014** code is reimbursed. If there is a state of emergency by the Governor’s Office, see MAD supplements found at:

https://www.hsd.state.nm.us/providers/Registers_and_Supplements.aspx

New Mexico does not require an in-state AEP/Qualifying Psychologist/BCBA-D/BCBA/BCaBA/RBT/BCAT/non-certified BT to have a telemedicine license. However, if the AEP is an out-of-state MD/DO, the New Mexico Medical Board does require this practitioner to obtain a telemedicine license (or a full New Mexico medical license).

1.5. Billing HCPCS T1026 UD in Partial Units

Billing in Partial Units of T1026 with any ABA modifier

Providers are instructed to submit claims as detailed below in the example.

Example 1 Paper Claim: HCPCS T1026 TG time code’s full 60-minute unit pays \$100 for one date of service. Provider K renders only 15 minutes for one date of service. Following the logic of **(1) below**:

- a. Providers are to calculate the percentage amount by multiplying the full amount by the **percentage** rendered, $\$100 \times 25\% = \25.00 . Enter on a CMS 1500 claim form **F**.
- b. Providers are to enter **a full unit of HCPCS time code of T1026 with any ABA Modifier**. Enter on CMS 1500 claim form **G**.
- c. **There are no Prior Authorization limits** for HCPCS timed code T1026 with any ABA modifier until such time as otherwise instructed.

| 24. A. | DATE(S) OF SERVICE | | | | | | B. | C. | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) | | E. | F. | G. |
|--------|--------------------|----|----|----|----|------------------|-----|-----------|---|-------------------|------------|---------------|----|
| | From | | To | | | PLACE OF SERVICE | EMG | CPT/HCPCS | MODIFIER | DIAGNOSIS POINTER | \$ CHARGES | DAYS OR UNITS | |
| | MM | DD | YY | MM | DD | YY | | | | | | | |

Taking the table from Section F of 8.302.2.10 NMAC and converting to percentages:

- 1. When billing 8 through 22 minutes, **bill 25% of the 100% of the full 60-minute unit.**
- 2. When billing 23 through 37 minutes, **bill 50% of the 100% of the full 60-minute unit.**
- 3. When billing 38 through 52 minutes, **bill 75% of the 100% of the full 60-minute unit.**
- 4. When billing 53 through 67 minutes, **bill 100% of the full 60-minute unit.**

Example 2 Electronic Claim: HCPCS T1026 TG time code’s full 60-minute unit pays \$100 for one date of service. Provider M renders only 15 minutes for one date of service. Following the logic of **(1) above**:

- a. Providers are to calculate the percentage amount by multiplying the full amount by the **percentage rendered**, $\$100 \times 25\% = \25.00 . Enter this amount in **item number 24F “Charges” on a CMS 1500 or in Loop ID 2400, Segment SV102 on 837P**.
- b. Providers are to enter a full unit of HCPCS time code of **T1026 with any ABA Modifier**. Enter this amount in **item number 24G “Days or Units” on a CMS 1500 or in Loop 2400 Segment SV104 on 837P**.

1.6 Identified Population

ABA Stage 1-3 services are provided to EPSDT-aged eligible recipients 12 months to 3 years meeting the At-Risk Criteria and other eligible recipients 12 months and older with a diagnosis of ASD or under EPSDT-aged Grace Period or Adult Grace Period. An eligible recipient may receive ABA Stage 1, 2, and 3 services if they are residing in a variety of living arrangements (such as but not limited to home, ARTC, supported living, nursing facility) and regardless of whether they are accessing other MAD medically warranted services. When the eligible recipient is accessing residential living (adult or EPSDT accredited residential center (ARTC), RTC, group), emergency room (ER), hospital inpatient admission or even a dental or vision visits, they are eligible to receive ABA Stage 1-3 services to assist the eligible recipient to fully benefit from these services.

An eligible recipient accesses ABA Stage 1 through 3 services through different paths. Depending on the age, an eligible recipient must complete a screening prior to accessing ABA Stage 1 Evaluation services. Due to the limited number of AEPs statewide, MAD allows a specific set of practitioners to render a Grace Period Exemption ASD diagnosis which allows an eligible recipient to start ABA Stage 2 and 3 services while waiting to complete ABA Stage 1 Evaluation. As adults in most cases have not received MAD ABA services, there are several points of entry to support their timely access to services.

Detailed in this supplement are the specifics of how each ABA stage of service is accessed and if a prior authorization is required. Each eligible recipient has a set Service Authorization and Prior Authorization period which details the types of services, the location of the services, and the practitioner rendering and supervising the services.

1.7 Screening and Referral

An EPSDT-aged recipient 12 months to 8 years must be screened prior to accessing ABA Stage 1 services. An eligible recipient beginning at age 8 and older is not required to be screened prior to accessing ABA EPSDT-aged or Adult services. A positive screening is when the EPSDT-aged eligible recipient is determined by the screener to have met the requirements to begin ABA Stage 1 services.

1.7.A Screening Tools

- c. A Level 1 ASD screener (e.g., Modified Checklist for Autism in Toddlers, Revised with Follow-Up; M-CHAT-R/F™ or Social Communication Questionnaire; SCQ) has been administered, and the screener yields a positive result; **and**
- d. The referring party believes the screener results to be valid based on their direct observation or eligible recipient’s development. Although not required, the referring party is encouraged to use a Level 2 screener (e.g., the Screening Tool for Autism in Toddlers™; STAT™) or gather additional information through another clinical assessment mechanism whenever the Level 1 screener result is inconsistent with other clinical data.

1.7.B Screeners:

1. The primary care provider (PCP) or another licensed health care practitioner including, but not limited to, a speech-language pathologist, occupational therapist, or a Medicaid enrolled behavioral health practitioner who is a LPCC, LISW/LCSW, psychologist, CNP or CNS, LMHC, or LMSW who also has qualifications to render a Level 2 screen; or
2. A FIT Program Service Coordinator, if the eligible recipient is concurrently being evaluated for FIT services or if he or she has been evaluated and is currently receiving FIT intervention services; or
3. A school-based health or educational professional involved in the EPSDT-aged eligible recipient's special education eligibility determination process.

1.7.C Results of Screening

If the screening results are positive, a referring practitioner may then refer the EPSDT-aged eligible recipient to an AEP for ABA Stage 1 services. The screener has three options:

1. The screening results do not lead to the suspicion of the EPSDT-aged eligible recipient having ASD;
2. The screening results do lead to the suspicion of the EPSDT-aged eligible recipient having ASD; the EPSDT-aged eligible recipient may then access ABA Stage 1 services;
3. The eligible recipient's screening results do lead to the suspicion the EPSDT-aged eligible recipient being at risk for developing ASD may then access ABA Stage 1 services.
4. Once the EPSDT-aged eligible recipient is diagnosed or is determined to be at-risk for ASD by an AEP, and if the EPSDT-aged recipient later discontinues Stage 2 and 3 services, upon reentry to Stage 2 services, they are not required to be rescreened.

1.7.C(1) Suspected of having ASD Criteria: An EPSDT-aged eligible recipient 12 months up to 3 years of age whose screening results support the probability they may be diagnosed with ASD, is referred to an AEP for ABA Stage 1 services.

1.7.C(2) At-Risk Criteria

An EPSDT-aged eligible recipient who meets the At-Risk criteria below may access ABA Stage 1 services. An EPSDT-aged eligible recipient 12 months to 3 years who screening determines they are at risk for developing ASD is referred to an AEP for an ABA Stage 1 At-Risk Evaluation, Risk (**T1026 HK**). The EPSDT-aged eligible recipient must have:

- a. Developmental differences and/or delays are measured by standardized assessment; and
- b. Presents some characteristics of the disorder (i.e., impairment in social communication and early indicators for the development of restricted and repetitive behavior); and
- c. Presents with at least one genetic risk factor (e.g., the EPSDT-aged eligible recipient has genetic risk due to having an older sibling with a well-documented medical diagnosis of ASD or the EPSTD-aged eligible recipient has a diagnosis of Fragile X syndrome).

2.3 ABA STAGE 1 SERVICES-EVALUATIONS

2. CDE (T1026 TG) and Targeted or Risk Evaluations (T2026TG/HI)-Stage 1 Services

2.1.A(1) Allowed Practitioners

Autism Evaluation Practitioner (AEP) – is a practitioner who meets the requirements to conduct the ABA Stage 1 Comprehensive Diagnostic Evaluation (CDE) (**T1026 TG**), Targeted Evaluation, or Risk Evaluation (**T1026 HK**). The AEP completes the Risk Evaluation Report and develops the Integrated Service Plan (ISP) (**T1026 TG/HI**) when the EPSDT-aged eligible recipient is diagnosed with ASD. For an EPSDT-aged eligible recipient who is determined to be At-Risk for developing ASD, the ISP (**T1026 TG/HI**) is embedded in the Risk Evaluation Report.

The AEP must develop a scheduling process to ensure priority is given to EPSDT-aged recipients who have the probability of being At-Risk for the development of ASD.

The AEP determines if the eligible recipient requires CDE (**T1026 TG**), the ISP (**T1026 TG/HI**), or Risk Evaluation (**T1026 HK**).

MAD approves individual AEPs. For a group or agency with two or more AEPs, each individual AEP must be approved. A group or agency is not recognized as an AEP group or agency via an agency specific attestation. If a new AEP joins a group or agency, that AEP must be individually approved.

2.1.A(2) Qualifications:

MAD enrolls individual AEPs, not an agency that employs or contracts with AEPs. Once approved the AEP may render ABA Stage 1 services to Fee-for-Service (FFS) benefit plan recipients. The AEP must be credentialed by the member's MCO prior to rendering ABA Stage 1 services. An AEP conducts CDE (**T1026 TG**), or Targeted/Risk Evaluation (**T1026 HK**), and develops the initial ISP (**T1026 TG/HI**) or ISP update (ISP update (**T1026 HK/HI**)) for an eligible recipient. An approved AEP must:

1. Be a New Mexico Regulation and Licensing Department (RLD) licensed, doctoral-level clinical psychologist or a physician who is board certified or board eligible in developmental behavioral pediatrics, pediatric neurology, child psychiatry, adolescent and adult psychiatry;
2. Have experience in, or knowledge of, the medically necessary use of ABA and other empirically supported intervention techniques;
3. Be qualified to conduct and document both CDE (**T1026 TG**), Targeted or Risk Evaluation (**T1026 HK**), ISP (**T1026 TG/HI**) and ISP update (**T1026 HK/HI**);
4. Have advanced training and clinical experience in the diagnosis and treatment of ASD and related neurodevelopment disorders, including knowledge about typical and atypical child, adolescent, and adult development and experience with variability within the ASD population;
5. Have advanced training in differential diagnosis of ASD from other developmental, psychiatric, and medical disorders;
6. Sign an attestation form affirming that all AEP practitioner requirements as outlined above have been and will continue to be met.

2.2.B Implementation of Evaluations

There are two types of s available to an EPSDT-age eligible recipient who has a positive screening, except when exempted, see 2.4 E: CDE (**T1026 TG**), and a Risk Evaluation (**T1026 HK**). It is the AEP's responsibility to provide information to the EPSDT-aged eligible recipient or their Family Set that describes the current presentation of the EPSDT-aged eligible recipient and all adjunct practitioners whose input is necessary to fully evaluate, write the report, and complete the ISP (**T1026 TG/HI**) which details and prioritizes medically necessary services to the EPSDT-aged eligible recipient, including ABA services, when appropriate. For an EPSDT-aged eligible recipient, a CDE (**T1026 TG**) or a Risk Evaluation (**T1026 HK**) must first be completed before a Targeted Evaluation (**T1026 HK**) is rendered.

2.2.B(1) - Comprehensive Diagnostic Evaluation (CDE) (T1026 TG) is used to confirm the presence of ASD, and must be conducted in accordance with current practice guidelines as offered by professional organizations such as the American Academy of Child and Adolescent Psychiatry, American Psychological Association, American Academy of Pediatrics, and American Academy of Neurology. CDE (**T1026 TG**) is a multi-informant and multi-modal evaluation process that allows for the careful evaluation of the presence of symptoms consistent with a diagnosis of ASD, and if a diagnosis is rendered, allows for the careful consideration of medically necessary services, including ABA. CDE includes a thorough review of the eligible recipient's behavior and development and includes interviewing the eligible recipient's Family Set. It may also include results of a hearing and vision screening, genetic

testing, neurological testing, and other medical testing. For an adult eligible recipient, a CDE may be rendered to better understand their behaviors and possible additional diagnoses that may better explain the adult eligible recipient's presentation.

1. An EPSDT-aged eligible recipient 12 months to 21 years of age, they must have an initial CDE, unless otherwise allowed under the EPSDT Grace Exception, see 3.2.1(E).
2. At any point during the eligible recipient's Service Authorization, the eligible recipient's presentation no longer matches their current CDE (**T1026 TG**) and the AEP determines it is medically warranted to conduct a CDE (**T1026 TG**) in lieu of completing a Targeted or Risk Evaluation, the eligible recipient's clinical file must document the medical necessity for a CDE. A new ISP (**T1026 TG/HI**) must be completed.
3. An EPSDT-age eligible recipient under 21 years, only one CDE (**T1026 TG**) is required, unless otherwise medically warranted. The EPSDT-aged eligible recipient thereafter completes a Targeted Evaluation (**T1026 HK**) and ISP (**T1026 TG/HI**) prior to the end of their Service Authorization.
4. When an EPSDT-aged eligible recipient has received a comparable CDE (**T1026 TG**) from a practitioner who at the time was not an AEP or an out of state practitioner both meeting the requirements of an AEP and has rendered a diagnosis of ASD, that EPSDT-aged eligible recipient is not required to complete an initial CDE (**T1026 TG**); however, an approved AEP must complete an initial ISP (**T1026 TG/HI**).

2.3.B(2) T1026 TG - CDE Adult or EPSDT Grace Exception:

HSD acknowledges the limited number of AEPs statewide and that eligible recipients often have their CDE (**T1026 TG**) or a Targeted or Risk Evaluation (**T1026 HK**) scheduled years in advance. This exception allows an eligible EPSDT-aged or an adult recipient to start ABA Stage 2 and 3 service in a timely manner.

2.3.B(2)(a) Grace Exception Practitioners

- i. A New Mexico Regulation and Licensing Department (RLD) licensed Psychologist;
- ii. For adult eligible recipient, a New Mexico Medical Board licensed MD or DO whose scope of practice allows them to render a diagnosis of ASD;
- iii. A New Mexico Board of Nursing licensed:
 - Psychiatric Clinical Nurse Specialist; or
 - Certified Nurse Practitioner with a specialty in Geriatrics, Pediatrics or Psychiatry.
- iv. For an EPSDT-aged eligible recipient, a New Mexico Medical Board licensed MD or DO specifically licensed as:
 - Psychiatrist who is Board Certified in Child and Adolescent; or
 - Pediatrician.

2.3.B(2)(b) CDE (T1026 TG) – CDE EPSDT Grace Exception

This exception allows a positive-screened EPSDT-aged eligible recipient aged 12-months to eight years who was previously diagnosed with ASD by one the practitioners listed above to access ABA Stage 2 and Stage 3 services. The EPSDT-aged eligible recipient must have a scheduled date to begin the CDE (**T1026 TG**) or Targeted or Risk Evaluation (**T1026 HK**) prior to accessing ABA Stage 2 and approved Stage 3 services. The EPSDT Grace Exception ends when the CDE (**T1026 TG**) is completed without a diagnosis of ASD or when Targeted or Risk Evaluation (**T1026 HK**) is completed with the AEP determining the eligible recipient is not at-risk for the development of ASD. MAD allows the EPSDT-aged eligible recipient to receive transitional ABA Stage 3 services for up to two months from the date the CDE (**T1026 TG**) or Targeted or Risk Evaluation (**T1026 HK**) is completed. If the EPSDT-aged eligible recipient is diagnosed with ASD or determined to be at-risk for ASD, they continue their previously authorized Stage 3 services while a new **97151** is completed utilizing the information from CDE (**T1026 TG**) or Targeted or Risk Evaluation (**T1026 HK**).

2.3.B(2)(c) CDE (T1026 TG) - CDE Adult Exception

For an eligible adult recipient, unless medically warranted, CDE (T1026 TG) is not required. The eligible adult recipient may without Prior Authorization, access ABA Stage 2 services and later ABA Stage 3. They must complete Targeted Evaluation (T1026 HK) and ISP (T1026 TG/HI) prior to the end of their first Service Authorization. At any point during the eligible adult recipient's Service Authorization their presentation no longer matches their current Targeted Evaluation (T1026 HK), and the AEP determines it is medically warranted to conduct Targeted Evaluation (T1026 HK) or a CDE (T1026 TG), the eligible adult recipient's clinical file must document the medical necessity for CDE (T1026 TG) or Targeted Evaluation (T1026 HK). A new ISP (T1026 TG/HI) must be completed.

2.3.B(2)(c)(i)

An eligible adult recipient who is turning 21 years of age and is currently accessing EPSDT-aged ABA services or ABA EPSDT Grace Period Stage 2 and 3 services, they may transition into MAD Adult ABA Stage 1-3 services without interruption when an ABA Stage 3 Treatment Plan for adults has been approved.

An eligible adult recipient who did not access EPSDT-age or EPSDT Grace ABA service may access ABA Stage 2 and 3 services (with the exception of 97156 and 97157) once their ABA Stage 3 Treatment Plan for adults has been approved and the eligible recipient has been diagnosed by their Grace Exception Practitioner within the last three years.

- a. If at any point during the eligible adult recipient's six-year Service Authorization, the AP agency or the eligible adult recipient determines CDE (T1026 TG) or Targeted Evaluation (T1026 HK) is medically warranted, the eligible adult recipient may access ABA Stage 1 services without Prior Authorization. The eligible adult recipient's medical record must document the medical necessary.
- b. The eligible adult recipient must continue during the six-year Service Authorization to be annually diagnosed with ASD by one of the Grace Exception Practitioners, and from them present a prescription for ABA Stage 2 and 3 services.
- c. The eligible adult recipient must annually complete an ABA Stage 2 Behavior or Functional Assessment (97151, 97152 and 0362T- collectively referred to as 97151 unless otherwise noted) with an updated ABA Treatment Plan. If medically warranted, 97151 may be conducted at any point. Medical necessity must be documented in the eligible adult recipient's clinical record.
- d. The Adult ABA Stage 3 Treatment Plan must be Prior Authorized annually during the eligible adult recipient's six-year Service Authorization.

2.3.B(3)(c)(ii)

An eligible adult recipient who has accessed ABA EPSDT Grace Period Stage 2 and 3 services, they may transition into Adult ABA Stage 1-3 services without interruption when a ABA Stage 3 Treatment Plan for adults has been approved and they have been previously diagnosed with ASD by any or combination of Grace Exemption Practitioner, at least three times prior to age 21.

1. If at any point during the eligible adult recipient's six-year Service Authorization period, the AP agency, eligible adult recipient or their appropriate member of the Family Set determines CDE (T1026 TG) or Targeted Evaluation (T1026 HK) is medically warranted, the eligible adult recipient may access ABA Stage 1 services without Prior Authorization. The eligible adult recipient's medical record must document the medical necessary.
2. The eligible adult recipient must continue during their six-year Service Authorization to annually be diagnosed with ASD by their Grace Exception Practitioner and from them present a prescription for ABA Stage 2 and 3 services.
3. The eligible adult recipient must without Prior Authorization annually complete 97151 with an updated ABA Treatment Plan. If medically warranted, ABA Stage 2 services may be conducted at

any point during the eligible adult recipient's Service Authorization. Medical necessity must be documented in their clinical record.

4. The Adult ABA Stage 3 Treatment Plan must be Prior Authorized annually during the eligible adult recipient's six-year Service Authorization.

2.3.B(3)(c)(iii)

An eligible adult recipient who did not access EPSDT-aged or EPSDT Grace ABA services may access ABA Stage 2 and 3 services once a ABA Stage 3 Treatment Plan for adults has been approved and the eligible adult recipient has been diagnosed by their Grace Exception Practitioner at any time in their medical history and there is a confirmation of ASD by a subsequent Grace Exception Practitioner within the last three years.

1. If at any point during the eligible adult recipient's six-year Service Authorization period, the AP agency, the eligible adult recipient or their appropriate member of the Family Set determines a CDE (**T1026 TG**) or Targeted Evaluation (**T1026 HK**) is medically warranted, the eligible adult recipient may access ABA Stage 1 services without Prior Authorization. Their medical record must document the medical necessary.
2. The eligible adult recipient must continue during their six-year Service Authorization to annually be diagnosed with ASD by their Grace Exception Practitioner and from them present a prescription for ABA Stage 2 and 3 services.
3. The eligible adult recipient must annually complete **97151** with an updated MAD ABA Treatment Plan. If medically warranted, **97151** may be conducted at any point. Medical necessity must be documented in the eligible adult recipient's clinical record.
4. The Adult ABA Stage 3 Treatment Plan must be prior authorized each year of the eligible adult recipient's six-year Service Authorization.

2.4 CONDUCTING CDE (T1026 TG) AND ISP (T1026 TG/HI)

2.4.A

The AEP must include the following elements when conducting and completing CDE (**T1026 TG**) and ISP (**T1026 TG/HI**).

2.4.A(1) Multi-informant:

A CDE (**T1026 TG**) must include information from the eligible recipient themselves via direct observation and interaction, interviews with the eligible recipient, their Family Set members, and for an eligible adult recipient in a residential or other congregated care setting, their caregivers or staff;

- a. Whenever possible, one additional informant who has direct knowledge of the eligible recipient's functioning as it pertains to skill deficits and behavioral excesses associated with ASD;
- b. For an EPSDT-aged eligible recipient, their educational or early interventionist providers; or
- c. The eligible recipient's physical, behavioral and long-term care health provider (e.g., speech-language pathologist, social worker, occupational therapist, physical therapist, psychologist, psychiatrist, behavior analyst, day habilitation services, PSR, Mi Via and DD waiver service providers).

2.4.A(2) Multi-modal:

T1027 TG must rely on various modes of information gathering, including but not limited to:

- a. For an EPSDT-aged eligible recipient, review of educational and/or early interventions, physical, behavioral and long-term care health records; and
- b. Legal guardian, primary caregiver, residential or congregated care staff and caregiver interviews for historical information, as well as determination of current symptom presentation; and
- c. Direct observation of, and interaction with the eligible recipient; and

- d. Clear consideration of, but ideally direct and/or indirect assessment of, multiple areas of functioning, including but not limited to:
 - i. developmental, intellectual, or cognitive functioning; and
 - ii. adaptive functioning; and
 - iii. social functioning; and
 - iv. speech, language, and communicative functioning; and
 - v. medical and neurological functioning.

2.4.B CDE (T1026 TG) and ISP (T1026 TG/HI) Requirements

A copy of the following documents must be included in the eligible recipient's record, and a copy must be provided to the eligible recipient or their appropriate Family Set member, and the PCP if different from the AEP.

- a. Within 60 calendar days of completion of CDE (T1026 TG), the AEP must issue a thorough report that documents the Evaluation process, Evaluation results, and case conceptualization and formulation, with special consideration of the criteria for ABA services for the eligible recipient. The CDE (T1026 TG) record must be signed by the AEP; and ISP (T1026 TG/HI) must be signed by the AEP, the eligible recipient or the eligible recipient's legal guardian. For each new CDE (T1026 TG), the AEP must issue an individualized ISP (T1026 TG/HI) and issue it within 30 calendar days (or no more than 45 calendar days) at the completion of CDE (T1026 TG).
- b. If the AEP determines that ABA services are clinically indicated, ISP (T1026 TG/HI) must include a statement that the AEP expects that the requested ABA services will likely result in measurable improvement in the eligible recipient's ASD symptomatology, associated behavioral excesses and deficits, and/or overall functioning, and ABA services are therefore prescribed.
- c. ISP (T1026 TG/HI) must ensure that all areas of need are adequately addressed through ABA and other medically necessary services (e.g., speech-language therapy, occupational therapy, specialized physical, behavioral, and long-term care health follow-up).
- d. ISP (T1026 TG/HI) must indicate what each recommended service provider should address in the context of their therapeutic work (i.e., what domains of functioning and what specific behavioral excesses or deficits they should target), and if appropriate what range of dosage of support the eligible recipient may consider upon completion of Stage 2 assessment. For example, 30-40 hour per week of ABA for a comprehensive program, or 15-20 hours per week for focused program for an eligible recipient with a Level 2 diagnosis.. As such, the AEP may include broadly constructed intervention goals, but should refrain from formulating specific objectives. Rather, the clinicians to whom the eligible recipient is ultimately referred should be responsible for creating their own discipline and domain-specific treatment plans, which should include this level of detail.
- e. ISP (T1026 TG/HI) must support access to, and participation in, services afforded through the Individuals with Disabilities Education Act (IDEA), including Part C for infants and toddlers and Part B for pre-school-aged children.
- f. The AEP must ensure that, if services other than ABA are prescribed, they are aligned with ABA such that the anticipated benefits to the eligible recipient can be realized. ABA alone has been shown to be less effective, and therefore it is necessary that the AEP design and document an ISP that includes complementary, rather than contraindicated, components.
- g. ISP (T1026 TG/HI) must be linked to findings from CDE (T1026 TG) and reflect input from the eligible recipient (as appropriate for age and developmental level), appropriate Family Set member as well as school staff and behavioral health professionals involved in the eligible recipient's care.
- h. ISP (T1026 TG/HI) development must include a realistic assessment of available resources as well as characteristics of the eligible recipient that may affect the intervention positively or negatively.
- i. ISP (T1026 TG/HI) must be based on the eligible recipient's current clinical presentation, while being mindful of the long-term vision for the eligible recipient's potential.
- j. ISP (T1026 TG/HI) must address needs associated with the eligible recipient's ASD-related symptoms, as well as symptoms associated with co-morbid conditions.

- k. Given that the needs of an eligible recipient with ASD are characteristically numerous, ISP (**T1026 TG/HI**) must establish clear priorities such that the most significant skill deficits and behavioral excesses are targeted first, with significance defined by the pivotal nature of the skill and/or by the risk that the skill's absence or behavioral excess poses to the eligible recipient or others.

2.4C An EPSDT-aged or Adult Grace Period Exception diagnosis of ASD or the recipient's ISP recommends ABA Stage 2 and 3 services, the TPA or the MCOs are to have considered the recipient meeting the admission criteria to begin ABA Stage 2 services. ABA Stage 3 services require only prior approval of **97153** services. If Specialty Care Services are medically warranted, the Specialty Care Practitioner must submit a Prior Authorization request for **0373T** services.

| 2.4.D Billing Instructions for T1026: TG & TG/HI | | |
|---|-------------------|---|
| Stage One Comprehensive Diagnostic Evaluation (CDE) | | |
| <p>T1026</p> <p>1st Modifier</p> <p>TG</p> <p>Mental Health Assessment</p> | <p>AEP</p> | <p><u>ABA Stage 1 – Comprehensive Diagnostic Evaluation (CDE)</u></p> <p>An eligible recipient 12 months up to 21 years of age must have an initial CDE (T1026 TG). Targeted Evaluation (T1026 HK) or Risk Evaluation is completed prior to the end of the eligible recipient's Service Authorization. No Prior Authorization is required.</p> <p>Bill partial T1026 units following directions under 1.2A</p> <p>Maximum units for CDE (T1026 TG) are ten 60-minute units in total.</p> <p><u>12 months to 21 years of age:</u></p> <p>If the AEP determines it is medically warranted for a new CDE (T1026 TG) be completed at any point during EPSDT-aged eligible recipient's Service Authorization no prior authorization is required; however, the EPSDT-aged eligible recipient's clinical file must document the medical necessity for CDE (T1026 TG) rather than complete Targeted or Risk Evaluation (T1026 HK).</p> <p><u>21 years and older:</u></p> <p>CDE (T1026 TG) is not required for an eligible adult recipient 21 years and older. If the AEP determines CDE (T1026 TG) is medically warranted at any point during the adult eligible recipient's Service Authorization, no Prior Authorization is required; however, the adult eligible recipient's clinical file must document the medical necessity for CDE (T1026 TG), rather than complete a Targeted Evaluation (T1026 HK).</p> <p>For an eligible recipient 12 months up to 3 years of age who meets the MAD At-Risk Criteria, the AEP completes a Risk Evaluation (T1026 HK), see below.</p> |

| | | |
|---|-------------------|---|
| | | <p>For every completed CDE (T1026 TG), an AEP must complete an ISP (T1026 TG/HI) - ISP when the eligible recipient is diagnosed with ASD.</p> <p><u>Concurrent Billing:</u> NONE</p> <p><u>In Conjunction with CDE (T1026 TG):</u> For an eligible recipient who is accessing ABA Stage 2 and 3 services these services may continue while the AEP completes CDE (T1026 TG). T1026 TG/HI</p> <p><u>Do Not Bill:</u> T1026 HK T1026 HK/HI</p> |
| <p>T1026 1st Modifier TG 2nd Modifier HI</p> | <p>AEP</p> | <p><u>ABA Stage 1 - Initial and Whenever CDE (T1026 TG) is Completed</u> For an EPSDT-aged eligible recipient who is 12 months up to 21 years of age whose AEP has completed CDE (T1026 TG) as an initial or new CDE, or for an adult eligible recipient 21 years of age and older whose AEP has completed CDE (T1026 TG) as an initial or new CDE, the AEP must complete a ISP (T1026 TG/HI).</p> <p>Maximum number of units per ISP (T1026 TG/HI): four 60-minute units.</p> <p><u>Concurrent Billing:</u> For an eligible recipient who is accessing ABA Stage 2 and 3 services these services may continue while the AEP completes ISP (T1026 TG/HI).</p> <p><u>In Conjunction with ISP (T1026 TG/HI):</u> For an eligible recipient who is accessing ABA Stage 2 and 3 services these services may continue while the AEP completes ISP (T1026 TG/HI). T1026 TG T1026 HK</p> <p><u>Do Not Bill:</u> T1026 HK/HI</p> |

2.4.E Conducting Targeted or Risk Evaluation (T1026 HK)-Targeted Evaluation

2.4.E(1) EPSDT-Aged Recipients:

An EPSDT-aged eligible recipient must have a current CDE (**T1026 TG**) in place before Targeted Evaluation (**T1026 HK**) is conducted. The EPSDT-aged eligible recipient, their AP agency or appropriate Family Set member may request the AEP to complete Targeted Evaluation (**T1026 HK**). The AEP evaluates the specific aspects of the EPSDT-aged eligible recipient’s current presentation to determine if Targeted Evaluation (**T1026 HK**) is medically warranted rather than CDE (**T1026 TG**). A new ISP (**T1026 TG/HI**) must be completed with Targeted Evaluation (**T1026 HK**).

If an EPSDT-aged eligible recipient has an evaluation completed within the past 24 months that meets CDE (T1026 TG) requirements that was conducted by an out of state non-AEP who meets the requirements of a AEP, but the CDE is lacking a ISP (T1026 TG/HI), the AEP conducts Targeted Evaluation (T1026 HK) for the purpose of developing the initial ISP T1026 TG/HI. The AEP is expected to use clinical discretion regarding the evaluation tools necessary to develop the ISP (T1026 TG/HI) that meets the eligible recipient's needs. Targeted Evaluation (T1026 HK) while focusing in on specific areas of the eligible recipient's current presentation, requires the same considerations and use of multi-informants as clinically indicated in CDE (T1026 TG). This means that for the specific behaviors or lack of behaviors being evaluated, the AEP must use their clinical judgement to determine whether another practitioner's input is required to produce a valid Targeted Evaluation (T1026 HK) and ISP (T1026 TG/HI).

2.4.E(2) Targeted Evaluation (T1026 HK) and ESPDT-aged Eligible Recipients 8 years to 21 years:

For these eligible recipients, Targeted Evaluation (T1026 HK) is required prior to the end of the EPSDT-aged eligible recipient's Service Authorization once a CDE (T1026 TG) was completed. At any point during the EPSDT-aged eligible recipient's Service Authorization their presentation no longer matches specific elements of their CDE (T1026 TG) and the AEP determines it is medically warranted to conduct Targeted Evaluation (T1026 HK) in lieu of completing a new CDE (T1026 TG), the EPSDT-aged eligible recipient's clinical file must document the medical necessity for Targeted Evaluation (T1026 HK). Targeted Evaluation (T1026 HK) may be completed at any point during the EPSDT-aged eligible recipient's Service Authorization without Prior Authorization. The clinical record must document the medical necessity for a new Targeted Evaluation (T1026 HK) rather than CDE (T1026 TG). A new ISP (T1026 TG/HI) must be completed.

2.4.E(3) Targeted Evaluation (T1026 HK) and Adult Eligible Recipients 21 years and Older:

For these eligible recipients, Targeted Evaluation (T1026 HK) is required prior to the end of their Service Authorization. At any point during the adult eligible recipient's Service Authorization their presentation no longer matches specific elements of their Targeted Evaluation (T1026 HK) and the AEP determines it is medically warranted to conduct Targeted Evaluation (T1026 HK) in lieu of completing CDE (T1026 TG), the adult eligible recipient's clinical file must document the medical necessity for Targeted Evaluation (T1026 HK). Targeted Evaluation (T1026 HK) may be completed at any point during their Service Authorization without Prior Authorization. A new ISP (T1026 TG/HI) must be completed.

2.5 CONDUCTING Targeted Evaluation (T1026 HK) AND ISP (T1026 TG/HI)

The AEP must include the following elements when conducting and completing Targeted/Risk Evaluation (T1026 HK) and ISP (T1026 TG/HI).

2.5.A Multi-informant:

Targeted Evaluation (T1026 HK) must include information from the eligible recipient themselves via direct observation and interaction, and their legal guardian or other primary caregiver; for an adult eligible recipient in a residential or other congregated care setting, information must come from their caregivers or staff. Whenever possible, one additional informant who has direct knowledge of the eligible recipient's functioning as it pertains to skill deficits and behavioral excesses associated with ASD should be included:

1. For an EPSDT-aged recipient, their educational or early interventionist providers; or

2. Recipient's physical, behavioral, and long-term care health provider (e.g., speech-language pathologist, social worker, occupational therapist, physical therapist, psychologist, psychiatrist, behavior analyst);
3. Day habilitation services, PSR, Mi Via and DD waiver service providers.

2.5.B Multi-modal:

T1027 HK must rely on various modes of information gathering, including but not limited to:

1. For an EPSDT-aged recipient, review of educational and/or early interventions, physical, behavioral, and long-term care health records; and
2. Legal guardian, primary caregiver, residential or congregated care staff and caregiver interviews for historical information, as well as determination of current symptom presentation; and
3. Direct observation of, and interaction with the eligible recipient; and
4. Clear consideration of, but ideally direct and/or indirect assessment of multiple areas of functioning, including but not limited to:
 - a. developmental, intellectual, or cognitive functioning; and
 - b. adaptive functioning; and
 - c. social functioning; and
 - d. speech, language, and communicative functioning; and
 - e. medical and neurological functioning.

2.5.C Targeted Evaluation (T1026 HK) and ISP (T1026 TG/HI) Requirements

A copy of the following documents must be included in the eligible recipient's record, and a copy must be provided to the eligible recipient or their legal guardian and the PCP, if different from the AEP.

1. Within 60 calendar days of completion of Target Evaluation (**T1026 HK**), the AEP must issue a thorough report that documents the evaluation process, valuation results, and case conceptualization and formulation, with special consideration of the criteria for ABA services for the eligible recipient. The Targeted Evaluation (**T1026 HK**) record must be signed by the AEP and the ISP (**T1026 TG/HI**) must be signed by the AEP, the eligible recipient or the eligible recipient's appropriate Family Set member. For each new Targeted Evaluation (**T1026 HK**) Targeted Evaluation, the AEP must issue an individualized ISP (**T1026 TG/HI**) and issue it within 30 calendar days (or no more than 45 calendar days) from the completion of Targeted Evaluation (**T1026 HK**).
2. If the AEP determines that ABA services are clinically indicated, ISP (**T1026 TG/HI**) must include a statement that the AEP expects that the requested ABA services will likely result in measurable improvement in the eligible recipient's ASD symptomatology, associated behavioral excesses and deficits, and/or overall functioning, and ABA services are therefore prescribed.
3. ISP (**T1026 TG/HI**) must ensure that all areas of need are adequately addressed through ABA and other medically necessary services (e.g., speech-language therapy, occupational therapy, specialized physical, behavioral, and long-term care health follow-up).
4. ISP (**T1026 TG/HI**) must indicate what each recommended service provider should address in the context of their therapeutic work (i.e., what domains of functioning and what specific behavioral excesses or deficits they should target). As such, the AEP may include broadly constructed intervention goals, but should refrain from formulating specific objectives. Rather, the clinicians to whom the eligible recipient is ultimately referred should be responsible for creating their own discipline and domain-specific treatment plans, which should include this level of detail.
5. ISP (**T1026 TG/HI**) must support access to, and participation in, services afforded through the Individuals with Disabilities Education Act (IDEA), including Part C for infants and toddlers and Part B for pre-school-aged children.
6. The AEP must ensure that if services other than ABA are prescribed, they are aligned with ABA such that the anticipated benefits to the eligible recipient can be realized. ABA alone has been shown to be less effective than a suite of complementary therapies, and therefore it is necessary that the AEP design and document an ISP that includes complementary, rather than contraindicated, components.

7. ISP (T1026 TG/HI) must be linked to findings from Targeted Evaluation (T1026 HK) and reflect input from the eligible recipient (as appropriate for age and developmental level), legal guardian, or other caretaker, as well as school staff and behavioral health professionals involved in the eligible recipient's care.
8. ISP (T1026 TG/HI) development must include a realistic assessment of available resources as well as characteristics of the eligible recipient that may affect the intervention positively or negatively.
9. ISP (T1026 TG/HI) must be based on the eligible recipient's current clinical presentation, while being mindful of the long-term vision for the eligible recipient's potential.
10. ISP (T1026 TG/HI) must address needs associated with the eligible recipient's ASD-related symptoms, as well as symptoms associated with co-morbid conditions.

Given that the needs of an eligible recipient with ASD are characteristically numerous, ISP (T1026 TG/HI) must establish clear priorities such that the most significant skill deficits and behavioral excesses are targeted first, with significance defined by the pivotal nature of the skill and/or by the risk that the skill's absence or behavioral excess poses to the eligible recipient or others.

For Billing Instructions, see Risk Evaluation, page 26.

2.6 Conducting Risk Evaluation (T1026 HK)

For an EPSDT-aged eligible recipient 12 months up to three years of age who met the MAD screening At-Risk Criteria, the AEP completes Risk Evaluation (T1026 HK). Risk Evaluation (T1026 HK) may be conducted at any point during the EPSDT-aged eligible recipient's Service Authorization as medically warranted without Prior Authorization. If the AEP determines the medical necessity for a new Risk Evaluation (T1026 HK) at any point during the EPSDT-aged eligible recipient's three-year Service Authorization, no Prior Authorization is required. The clinical record must document the medical necessity for a new Risk Evaluation (T1026 HK) rather than completing a CDE (T1026 TG). It is not unusual due to the young ages of the eligible recipients for their presentation to change within their Service Authorization period enough to warrant new Risk Evaluation (T1026 HK). A T1026 TG/HI must be completed.

2.6.A T1026 TG/HI - Integrated Service Plan (ISP):

An ISP is a detailed document which pulls together the results of the CDE (T1026 TG) or Risk Evaluation (T1026 HK) into an integrated plan which prioritizes all medically necessary services. Results of the Risk Evaluation (T1026 HK) are used to develop the initial ISP (T1026 TG/HI). ISP (T1026 TG/HI) is required under ABA Stage 1 services as a separate document or as an embedded part of the Risk Report.

The AEP must include the following elements when completing the Risk Evaluation (T1026 HK) Risk Evaluation Report and developing the eligible recipient's ISP (T1026 TG/HI).

2.6.A(1) Multi-informant:

Risk Evaluation (T1026 HK) must include information from the ESPDT-aged eligible recipient themselves via direct observation and interaction, and their legal guardian or other primary caregiver. Whenever possible, include one additional informant who has direct knowledge of the EPSDT-aged eligible recipient's functioning as it pertains to skill deficits and behavioral excesses associated with ASD:

- a. Their educational or early interventionist provider, Early Head Start, childcare provider; or

- b. Their physical, behavioral, and long-term care health provider (e.g., Speech-Language Pathologist, Social Worker, Occupational Therapist, Physical Therapist, Psychologist, Psychiatrist, Behavior Analyst, etc.).

2.6.A(2) Multi-modal:

T1027 HK Risk Evaluation must rely on various modes of information gathering, including but not limited to:

- a. For an EPSDT-aged eligible recipient twelve months up to three years, review of educational and/or early interventions, physical, behavioral, and long-term care health records; and
- b. Legal guardian, primary caregiver interviews for historical information, as well as determination of current symptom presentation; and
- c. Direct observation of, and interaction with the EPSDT-aged eligible recipient; and
- d. Clear consideration of, but ideally direct and/or indirect assessment of multiple areas of functioning, including but not limited to:
 - i. developmental, intellectual, or cognitive functioning; and
 - ii. adaptive functioning; and
 - iii. social functioning; and
 - iv. speech, language, and communicative functioning; and
 - v. medical and neurological functioning.

2.6.B T1026 - HK Risk Evaluation and ISP (T1026 TG/HI) Requirements

A copy of the following documents must be included in the EPSDT-aged eligible recipient's record, and a copy must be provided to their legal guardian and the PCP, if different from the AEP.

1. Within 60 calendar days of completion of Risk Evaluation (**T1026 HK**), the AEP must issue a thorough report that documents the Evaluation process, Evaluation results, and case conceptualization and formulation, with special consideration of the criteria for ABA services for the EPSDT-aged eligible recipient. The Risk Evaluation (**T1026 HK**) record must be signed by the AEP; and the ISP (**T1026 TG/HI**) must be signed by the AEP and the EPSDT-aged eligible recipient's legal guardian. For each new Risk Evaluation (**T1026 HK**), the AEP must issue an individualized ISP (**T1026 TG/HI**) and issue it within 30 calendar days (or no more than 45 calendar days) at the completion of Risk Evaluation (**T1026 HK**).
2. If the AEP determines that At-Risk ABA services are clinically indicated, ISP (**T1026 TG/HI**) must include a statement that the AEP expects that the requested ABA services will likely result in measurable improvement in the EPSDT-aged eligible recipient's possible ASD symptomatology, associated behavioral excesses and deficits, and/or overall functioning, and ABA services are therefore prescribed.
3. ISP (**T1026 TG/HI**) must ensure that all areas of need are adequately addressed through ABA and other medically necessary services (e.g., speech-language therapy, occupational therapy, specialized physical, behavioral, and long-term care health follow-up,).
4. ISP (**T1026 TG/HI**) must indicate what each recommended service provider should address in the context of their therapeutic work (i.e., what domains of functioning and what specific behavioral excesses or deficits they should target). As such, the AEP may include broadly constructed intervention goals, but should refrain from formulating specific objectives. Rather, the clinicians to whom the EPSDT-aged eligible recipient is ultimately referred should be responsible for creating their own discipline and domain-specific treatment plans, which should include this level of detail.
5. ISP (**T1026 TG/HI**) must support access to, and participation in, services afforded through the IDEA including Part C for infants and toddlers and Part B for pre-school-aged children.
6. The AEP must ensure that, if services other than ABA are prescribed, they are aligned with ABA such that the anticipated benefits to the EPSDT-aged eligible recipient can be realized. ABA alone has been shown to be less effective than a suite of complementary therapies, and therefore it is

necessary that the AEP design and document ISP (**T1026 TG/HI**) that includes complementary, rather than contraindicated, components.

7. ISP (**T1026 TG/HI**) must be linked to findings from Risk Evaluation (**T1026 HK**) and reflect input from the EPSDT-aged eligible recipient (as appropriate for age and developmental level), legal guardian, or other caretaker, as well as school staff and behavioral health professionals involved in the EPSDT-aged eligible recipient’s care.
8. ISP (**T1026 TG/HI**) development must include a realistic assessment of available resources as well as characteristics of the EPSDT-aged eligible recipient that may affect the intervention positively or negatively.
9. ISP (**T1026 TG/HI**) must be based on the EPSDT-aged eligible recipient’s current clinical presentation, while being mindful of the long-term vision for the EPSDT-aged eligible recipient’s potential.
10. ISP (**T1026 TG/HI**) must address needs associated with the EPSDT-aged eligible recipient’s ASD-related symptoms, as well as symptoms associated with co-morbid conditions.
Given that the needs of an EPSDT-aged eligible recipient with ASD are characteristically numerous, ISP (**T1026 TG/HI**) must establish clear priorities such that the most significant skill deficits and behavioral excesses are targeted first, with significance defined by the pivotal nature of the skill and/or by the risk that the skill’s absence or behavioral excess poses to the EPSDT-aged eligible recipient or others.

An EPSDT-aged or Adult Grace Period Exception diagnosis of ASD or the recipient’s ISP recommends ABA Stage 2 and 3 services, the TPA or the MCOs are to have considered the recipient meeting the admission criteria to begin ABA Stage 2 services. ABA Stage 3 services require only prior approval of **97153** services. If Specialty Care Services are medically warranted, the Specialty Care Practitioner must submit a Prior Authorization request for **0373T** services.

2.6.C Billing for Targeted Evaluation or Risk Evaluation T1026: HK, TG and HI

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|--|-------------------|--|
| <p>T1026</p> <p>1st Modifier</p> <p>HK</p> | <p>AEP</p> | <p><u>ABA Stage 1 – Targeted Evaluation or Risk Evaluation</u></p> <p><u>Targeted Evaluation:</u> Maximum number of units per Targeted or Risk Evaluation (T1026 HK): five 60-minute units. Bill partial T1026 units following directions under 1.2A</p> <p>At any point during the eligible recipient’s Service Authorization when the eligible recipient’s presentation no longer matches specific elements of their CDE (T1026 TG) and the AEP determines it is medically warranted to conduct Targeted Evaluation (T1026 HK) in lieu of completing a new CDE (T1026 TG), the eligible recipient’s clinical file must document the medical necessity for Targeted Evaluation (T1026 HK). No prior authorization is required.</p> <p>For the EPSDT-aged eligible recipient who has an initial CDE (T1026 TG), Targeted Evaluation (T1026 HK) is completed prior to the end of their Service Authorization.</p> |
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| | | <p>For an adult eligible recipient, a Targeted Evaluation (T1026 HK) is completed prior to the end of their Service Authorization.</p> <p>The AEP must complete ISP (T1026 TG/HI) with each Targeted Evaluation (T1026 HK).</p> <p>Do not complete Targeted Evaluation (T1026 HK) with ISP update (T1026 HK/HI).</p> <p><u>Risk Evaluation:</u> For an eligible recipient 12 months up to 3 years of age who meets the MAD At-Risk Criteria, the AEP completes Risk Evaluation (T1026 HK). No Prior Authorization is required.</p> <p>If the AEP determines the medical necessity for a new Risk Evaluation (T1026 HK) at any point during the EPSDT-aged eligible recipient’s Service Authorization, no Prior Authorization is required; however, their clinical file must document the medical necessity for a new Risk Evaluation (T1026 HK) rather than complete a CDE (T1026 TG). It is not unusual for the EPSDT-aged eligible recipient’s presentation to change within their Service Authorization enough to warrant new Risk Evaluation (T1026 HK).</p> <p>Maximum number of units per Targeted or Risk Evaluation (T1026 HK): five 60-minute units.</p> <p>The AEP must complete ISP (T1026 TG/HI) for each Targeted or Risk Evaluation (T1026 HK).</p> <p><u>Concurrent Billing:</u> NONE</p> <p><u>In Conjunction with Targeted or Risk Evaluation (T1026 HK):</u> For an eligible recipient who is accessing ABA Stage 2 and 3 services, these services may continue while the AEP completes ISP update (T1026 TG/HI)</p> <p><u>Do Not Bill:</u> T1026 TG T1026 HK/HI</p> |
| <p>T1026 1st Modifier TG</p> <p>2nd Modifier HI</p> | <p>AEP</p> | <p><u>ABA Stage 1 - ISP Initial and Ongoing for Targeted or Risk Evaluation</u> ISP (T1026 TG/HI) may be completed at any point during the eligible recipient's Service Authorization when the AEP completes a Targeted or Risk Evaluation (T1026 HK). No Prior Authorization is required.</p> <p>Maximum number of units per ISP (T1026 TG/HI): three 60-minute. units.</p> <p><u>Concurrent Billing:</u></p> |

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| | | <p style="text-align: center;">NONE</p> <p><u>In Conjunction with ISP (T1026 TG/HI):</u> For an eligible recipient who is accessing ABA Stage 2 and 3 services these services may continue while the AEP completes ISP (T1026 TG/HI). T1026 TG T1026 HK</p> <p><u>Do Not Bill:</u> T1026 HK/HI</p> |
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2.7 Update to the ISP (T1026 HK/HI) -

When an eligible recipient’s presentation no longer matches specific areas of their current ISP (T1026 TG/HI), but the AEP determines a new CDE (T1026 TG), Targeted or Risk Evaluation (T1026 HK) is not medically warranted, then the AEP completes an update to the eligible recipient’s current ISP (T1026 TG/HI) and bills ISP update (T1026 HK/HI).

2.7.A ISP update (T1026 HK/HI) Requirements

A copy of the following documents must be included in the eligible recipient’s record, and a copy must be provided to the eligible recipient or their legal guardian and the PCP, if different from the AEP.

1. Within 30 calendar days the AEP’s determination the eligible recipient requires only ISP update (T1026 HK/HI) instead of new CDE (T1026 TG) or Targeted or Risk Evaluation (T1026 HK) the AEP must issue a thorough report that documents the AEP’s conceptualization and formulation of ISP update (T1026 HK/HI), with special consideration of the criteria for ABA services for the eligible recipient. ISP update (T1026 HK/HI) must be signed by the AEP, the eligible recipient or their appropriate Family Set member.
2. ISP update (T1026 HK/HI) must support access to, and participation in, services afforded through IDEA, including Part C for infants and toddlers and Part B for pre-school-aged children.
3. The AEP must ensure that, if services other than ABA are prescribed, they are aligned with ABA such that the anticipated benefits to the eligible recipient can be realized. ABA alone has been shown to be less effective, and therefore it is necessary that the AEP design and document in ISP update (T1026 HK/HI) that includes complementary, rather than contraindicated, components.
4. ISP update (T1026 HK/HI) must be linked to findings from CDE (T1026 TG) or Targeted or Risk Evaluation (T1026 HK) and reflect input from the eligible recipient (as appropriate for age and developmental level), legal guardian, or other caretaker, as well as school staff and behavioral health professionals involved in the eligible recipient’s care.
5. ISP update (T1026 HK/HI) development must include a realistic assessment of available resources as well as characteristics of the eligible recipient that may affect the intervention positively or negatively.
6. ISP update (T1026 HK/HI) must be based on the eligible recipient’s current clinical presentation, while being mindful of the long-term vision for the eligible recipient’s potential.
7. ISP update (T1026 HK/HI) must address needs associated with the eligible recipient’s ASD-related symptoms, as well as symptoms associated with co-morbid conditions.
8. Given that the needs of an eligible recipient with ASD are characteristically numerous, ISP update (T1026 HK/HI) must establish clear priorities such that the most significant skill deficits and behavioral excesses are targeted first, with significance defined by the pivotal nature of the skill and/or by the risk that the skill’s absence or behavioral excess poses to the eligible recipient or others.

2.7.B Billing Instructions for Targeted or Risk Evaluation (T1026 HK) and HI ISP Update

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|---|-------------------|---|
| <p>T1026</p> <p>1st Modifier HK</p> <p>2nd Modifier HI</p> | <p>AEP</p> | <p><u>ABA Stage 1 - ISP Update</u></p> <p>For an eligible recipient whose presentation changes from the current ISP (T1026 TG/HI) and the change does not necessitate a new CDE (T1026 TG) or a Targeted or Risk Evaluation (T1026 HK), the AEP updates the eligible recipient’s ISP and bills ISP update (T1026 HK/HI). The clinical record must document the medical necessity for ISP update (T1026 HK/HI).</p> <p>ISP update (T1026 HK/HI) may be completed at any point during the eligible recipient’s current Service Authorization period when medically warranted without Prior Authorization. The clinical record must document the medical necessity.</p> <p>Maximum number of units per ISP update (T1026 HK/HI): two 60-minute units.</p> <p>Bill partial T1026 units following directions under 1.2A</p> <p><u>Concurrent Billing:</u> NONE</p> <p><u>In Conjunction with ISP update (T1026 HK/HI):</u> For an eligible recipient who is accessing ABA Stage 2 and 3 services, or if approved for the EPDST or Adult Grace Exemption who is receiving ABA Stage 2 and 3 services (as approved), these services may continue while the AEP completes ISP update (T1026 HK/HI).</p> <p><u>Do Not Bill:</u> T1026 TG T1026 HK -Targeted Evaluation or Risk Evaluation T1026 TG/HI - ISP</p> |
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ABA Stage 2 and 3 CPT Codes

3.1 ABA Stage 2 – Assessment and Treatment Planning

| Billing Code | American Medical Association (AMA) CPT Descriptor |
|---------------------|---|
| 97151 | Behavior Identification Assessment, administered by QHP, each 15 minutes of QHP’s time face-to-face with patient and/or guardian(s)/caregivers(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 QHP, face-to-face with the patient, each 15 minutes |

- 0362T** Behavior Identification Supporting Assessment, each 15 minutes of technicians' time face-to-face with patient, requiring four components: QHP on site; assistance of 2+ technicians; patient with destructive behavior; environment customized to patient behavior
- 97153** Adaptive Behavior Treatment by Protocol, administered by technician under the direction of a QHP, face-to-face with one patient, each 15 minutes
- 97154** Group Adaptive Behavior Treatment by Protocol, administered by technician under direction of QHP, face-to-face with 2+ patients, each 15 minutes
- 97155** Adaptive Behavior Treatment with Protocol Modification, administered by QHP, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes
- 97156** Family Adaptive Behavior Treatment Guidance, administered by QHP (with or without patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes
- 97157** Multiple-Family Group Adaptive Behavior Treatment Guidance, administered by QHP (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 QHP face-to-face with multiple patients, each 15 minutes
- 0373T** Adaptive Behavior Treatment with Protocol Modification, each 15 minutes of technicians' time face-to-face with patient, requiring four components: QHP on site; assistance of 2+ technicians; patient with destructive behavior; environment customized to patient behavior

3 ABA Stage 2

3.1.A ABA Stage 2 and 3 Practitioners

3.1.A(1) Behavior Analyst (BA) is a practitioner who meets the Behavior Analyst Certification Board (BACB) definition of a Qualifying Psychologist (a New Mexico Regulation and Licensing Department Psychologist Examiners Board licensed psychologist who is also certified by the American Board of Professional Psychology as a Behavioral and Cognitive Psychologist who was tested in ABA), a Board Certified Behavior Analyst-Doctorate (BCBA-D), or a Board Certified Behavior Analyst (BCBA) who each is recognized by the BACB to supervise a Board Certified Assistant Behavior Analyst (BCaBA), Registered Behavior Technician (RBT), Behavior Interventionist Certification Council (BICC) Board Certified Autism Technician (BCAT), and provides MAD required supervision to a BAA/RBT/BCAT/non-certified Behavior Technician, and mentors an entry level BA (Mentored BA) for two years. A BA must successfully complete a criminal background registry check and possess and maintain their license or BCBA certification.

3.1.A(2) Mentored BA is a BA who has been certified less than three years and is supervised by a BA with at least three years of BA supervision experience. A Mentored BA must successfully complete a criminal background registry check and possess and maintain their BCBA certification.

3.1.A(3) Behavior Assistant Analyst (BAA) means a BCaBA who must successfully complete a criminal background registry check and possess and maintain their BCaBA certification. A supervising BAA is a BCaBA who has successfully completed their BACB supervision requirements.

3.1.A(4) Behavior Technician (BT) is an RBT, BCAT or a non-certified behavior technician (time limited to six months from first date of billing as a non-certified BT).

3.1.A (5) Registered Behavior Technician (RBT) means a practitioner who the BACB recognizes as a RBT who:

1. Is at least 18 years of age;
2. Possesses a minimum of a high school diploma or equivalent; and
3. A RBT must complete four hours of ASD training including but not limited to training about prevalence, etiology, core symptoms, characteristics, and learning differences, in addition to any other BACB requirements.
4. A RBT must successfully complete a criminal background registry check and possess and maintain their RBT credential.

3.1.A(7) Board Certified Autism Technician (BCAT) means a practitioner who the Behavioral Intervention Certification Councils (BICC) recognizes as a BCAT who:

1. Is at least 18 years of age;
2. Possesses a minimum of a high school diploma or equivalent; and
3. Successfully completed a criminal background registry check.
4. A BCAT must successfully complete a criminal background registry check and possess and maintain his or her BCAT certification.

3.1.A(8) Non-certified Behavior Technician means a non-certified RBT or BCAT who:

1. Is at least 18 years of age;
2. Possesses a minimum of a high school diploma or equivalent;
3. Successfully completed a New Mexico criminal background registry check;
4. Completed a minimum of four hours of training in ASD including but not limited to training about prevalence, etiology, core symptoms, characteristics, and learning differences prior to rendering ABA Stage 2 and 3 services;
5. Within the first 90-calendar days of approval as a Non-certified Behavior Technician, completed 40 hours of training in ABA (provided by a BACB approved trainer) that meets RBT or BCAT certification requirements;
6. Prior to rendering ABA services has completed at least twenty hours of the required RBT or BCAT trainings;
7. Within the first 90-calendar days of approval as a Non-certified Behavior Technician, completed all other requirements to be approved for a RBT or BCAT testing date (e.g., passing the identified competency assessment, submitting the necessary documentation to the BACB or BICC); and
8. Secures and hold a RBT or BCAT certificate within the first continuous six- months of approval as a Non-certified Behavior Technician.
9. If the non-certified BT failed to earn their certification within the allotted timeframe, the non-certified BT must not render ABA Stage 2 or 3 services until they are a certified as a RBT or BCAT.

3.2.B Behavior Identification Assessment (97151) Stage 2 Service

If the AEP diagnoses the eligible recipient with ASD or at risk of developing ASD and recommends ABA services as part of the eligible recipient's ISP (**T1026 TG/HI**), the BA/Mentored BA conducts **97151**, and as necessary the **97152** or the **0362T** ABA Stage 2 Behavior or Functional Analytic Assessments. Utilizing the results of **97151**, an ABA Treatment Plan is completed. It is the BA's/Mentored BA's responsibility to provide information which fully describes the current presentation of the eligible recipient and all adjunct practitioners whose input is necessary to fully complete **97151** and an ABA Treatment Plan. The ABA Treatment Plan prioritizes goals for the

eligible recipient to ensure the health and safety of the eligible recipient and their family. Unless otherwise noted, the use of **97151** is inclusive of the **97152** or **0362T**.

3.2.B(1) Impact of Adult and EPSDT Grace Exceptions

The eligible recipient, parent or guardian provides the AP agency the eligible recipient's ASD diagnosis rendered by one of the approved Adult and EPSDT-aged Grace Exceptions practitioners. The AP agency begins ABA Stage 2 services. These services continue until CDE (**T1026 TG**) or Targeted or Risk Evaluation (**T1026 HK**) is completed. The eligible recipient under an EPSDT-aged or Adult Grace Exception Period receive the same services as an eligible recipient who holds a Stage 1 CDE, At-Risk evaluation, or a Targeted evaluation.

3.2.B(1)(a) If the EPSDT-aged recipient's diagnosis of ASD is confirmed by an AEP, they continues with ABA Stage 2 services and approved ABA Stage 3 services. The EPSDT-aged eligible recipient must annually complete **97151** without Prior Authorization and be approved for ABA Stage 3 services.

3.2.B(1)(b) If the adult recipient's annual diagnosis of ASD is confirmed by an Adult Grace Exception approved practitioner, the adult recipient continues ABA Stage 2 services and approved ABA Stage 3 services. The annual **97151** must be completed for services and be approved for ABA Stage 3 services.

3.2.C Behavior or Functional Assessments - 97151, 97152 and 362T

Unless otherwise stated, **97151** includes the results of **97152** and **0362T**. The BA/Mentored BA conducting **97151** incorporates developmentally appropriate questions for the eligible recipient assessment strategies and assessment measures. The Behavior or Functional Analytic Assessment must identify strengths and weaknesses across domains. The information from the assessment is the basis for developing the individualized ABA Treatment Plan. **97151** should utilize data obtained from multiple methods and multiple informants, such as:

3.2.C(1) Direct observation and measurement of behavior: Direct observation, measurement, and recording of behavior are defining characteristics of ABA services. The data serve as the primary basis for identifying pre-treatment levels, discharge goals, and evaluation of response to an ABA Treatment Plan. Direct observation and measurement of behavior assists the BA in developing and adapting treatment protocols on an ongoing basis. Direct observation of behavior should happen during naturally occurring opportunities as well as structured interactions.

3.2.C(2) File review and administration of behavior scales or other assessments as appropriate: The types of assessments utilized by the BA/Mentored BA should reflect the goal of treatment and should be responsive to ongoing data as they are collected and analyzed.

3.2.C(3) Interviews with the eligible recipient, members of the Family Set, and other professionals: Members of the Family Set and other stakeholders are included when selecting treatment goals, protocols, and evaluating progress. These interviews, rating scales, and social validity measures should be used to assess the legal guardian and caregiver's perceptions of the eligible recipient's skill deficits and behavioral excesses, and the extent to which these deficits and excesses impede the functioning of the eligible recipient and member of their Family Set. The eligible recipient should also participate in these processes as developmentally appropriate.

3.2.D Selection and Measurement of Goals

Once the information has been gathered and **97151** has been completed, the BA/Mentored BA must select goals for intervention and determine how these goals will be measured.

Development of a target-behavior definition, method and frequency of measurement, and data presentation must be individualized to each situation, behavior, and available resources.

Behavioral targets should be prioritized based on their risk to the eligible recipient's safety, independence, and implications for their short and long-term health and well-being.

Baseline performance should be measured, and treatment goals should be developed for each critical domain and specified in terms that are observable and measurable so that there is agreement between stakeholders (i.e., the eligible recipient, their legal guardian, the AP agency, TPA or the MCO) regarding the presence, absence, or degree of behavior change relative to treatment goals and discharge criteria.

The ABA Treatment Plan should specify objective and measurable treatment protocols.

3.2.E Service Model Determination:

Treatment may vary in terms of intensity and duration, the complexity and range of treatment goals, and the extent of direct treatment provided. Many variables, including the number of behavioral targets, specific aspects of those behaviors, and the eligible recipient's response to treatment protocols help determine which model is most appropriate. Although existing on a continuum, these models can be generally categorized as Focused ABA or Comprehensive ABA.

3.2.E(1) Focused ABA:

Refers to an approach to the treatment for limited number of behavioral targets. Although the presence of a problem behavior may trigger a decision for Focused ABA services more often than skill deficits, the absence of appropriate behaviors should be prioritized, as this is often the precursor to serious behavior problems. Therefore, an eligible recipient who needs to acquire or maintain skills (e.g., communication, tolerating change in environments and activities, self-help, social skills) is also appropriate for Focused ABA. All Focused ABA Treatment Plans that target reduction of dangerous or maladaptive behavior must concurrently introduce and strengthen more appropriate, functional behavior.

3.2.E(1)(a) Examples of skill acquisition targets in a Focused ABA Treatment Plan include, but are not limited to, establishing compliance with medical and dental procedures, sleep hygiene, self-care skills, and safe and independent play/leisure skills.

3.2.E(1)(b) Examples of behavior reduction targets in a Focused ABA Treatment Plan include, but are not limited to, self-injury, aggression towards others, dysfunctional speech, stereotypic motor behavior, property destruction, noncompliance and disruptive behavior, and dysfunctional social behavior.

3.2.E(1)(d) Focused ABA generally ranges from 10-25 hours per week of direct treatment (plus direct and indirect supervision and caregiver training). However, certain programs for severe destructive behavior may require more than 25 hours per week of direct therapy (for example, day treatment or inpatient program for severe self-injurious behavior). Dosage is determined by individualized factors and MAD requires the MCO to adhere to the recommendations from within the individual's ISP, the Grace Exception Practitioner, and/or Level of ASD diagnosis, as well as the recommendations from the ABA provider based on the eligible recipient's skill deficits as shown in the Stage 2 assessment. Individuals requiring substantial support (Level 2) or very substantial support (Level 3), will likely require a higher dosage of treatment under the selected service model. The BA will develop a discharge plan and as the eligible recipient demonstrates that they have met the discharge goals, dosage is systematically faded and may be provided at fewer than 10 hours as they prepare for discharge.

3.2.E(2) Comprehensive ABA:

Refers to an intensive intervention and treatment where there are multiple targets across most or all developmental domains that are affected by the eligible recipient's ASD.

EPSDT-Aged Eligible Recipient: The overarching goal of early, intensive, behavioral intervention is to move to close the gap between their level of functioning and that of typical peers.

Adult Eligible Recipients: The goal is not necessarily to move or close the gap between their level of functioning and their peers, it is to look at a comprehensive program to:

- treat multiple domains across many different environments, particularly if there are severe or high-risk behaviors;
- train and support a variety of caregivers from the Family Set to ensure continuity of care and generalization across environments/providers;
- increase participation in routines to maintain good health (e.g., dental/medical exams), safety and independent living.

3.2.E(2)(a) Initial treatment is often intensive and provided mostly in structured intervention sessions. Less structured treatment approaches are utilized if the eligible recipient demonstrates the ability to benefit from them. As the eligible recipient progresses and meets established criteria for participation in larger or different settings, treatment in those settings and in the larger community should be provided.

3.2.E(2)(a)(i) Targets are drawn from multiple domains related to cognitive, communicative, social, emotional, and adaptive functioning. Targets also include reducing maladaptive behavior such as aggression, self-injury, disruption, and stereotypy. Given the nature of comprehensive intervention, there must be a Prior Authorization from the EPSDT-aged recipient's MCO or TPA if services are rendered less than 10 hours per week on average. For an adult recipient, Comprehensive Services may range from forty 15-minute units (ten hours) to 160 15-minute units (40 hours), dependent on their Adult Tier.

3.2.E(2)(a)(ii) Treatment often involves an intensity level of 30-40 hours of 1:1 direct treatment to the eligible recipient per week, not including Family Set training, supervision, and other needed services. Dosage is determined by individualized factors and MAD requires the MCO to adhere to the recommendations from within the eligible recipient's ISP, the Grace Exception Practitioner, and/or Level of ASD diagnosis, as well as the recommendations from the ABA provider based on the eligible recipient's skill deficits as shown in the Stage 2 assessment. Eligible recipients requiring substantial support (Level 2) or very substantial support (Level 3), will likely require a higher dosage of treatment under the selected service model. Treatment hours are increased or decreased as a function of the eligible recipient's response to treatment as well as the intensity needed to reach treatment goals. In some cases, direct treatment hours increase gradually, are maintained at maximum intensity for a period and are then systematically decreased in preparation for focused approach. In other cases, treatment may begin at maximum levels.

3.2.E(2)(a)(iii) Training and participation by members of the Family Set are also seen as important components. Every Treatment Plan must include ample units of ABA Stage 3 **97156** and **97157**. For a member of the Family Set who is unable to participate in every ABA Stage 3 session, the BA/Mentored BA is required to provide alternative methods of access such as the use of telemedicine to encourage the participation of the eligible recipient's Family Set members.

3.2.F Selection and Measurement of Goals

Once **97151** has been completed, the BA/Mentored BA must select goals for intervention and determine how these goals will be measured. The MCO or TPA will review the goals and progress for each Prior Authorization of **97153** and **0373T** for ABA Stage 3 services is requested. Selection and development of measurements and goals should include each of the following.

3.2.F(1) Development of a target-behavior definition, method and frequency of measurement, and data presentation must be individualized to each situation, behavior, and available resources.

3.2.F(2) Behavioral targets should be prioritized based on their risk to eligible recipient's safety, independence, and implications for their short and long-term health and well-being.

3.3.8.F(3) Baseline performance should be measured, and treatment goals should be developed for each critical domain and specified in terms that are observable and measurable so that there is agreement between stakeholders (i.e., the eligible recipient, their legal guardian, the AP, the MCO or

TPA) regarding the presence, absence, or degree of behavior change relative to treatment goals and discharge criteria.

3.2.F(4) The ABA Treatment Plan should specify objective and measurable treatment protocols. It should include the service setting and level of service for the eligible recipient. Data collection and analysis by the supervising BA/Mentored BA should occur frequently enough to permit changes to intervention procedures at a rate that maximizes progress. Data should be represented in graphical form, with visual inspection of graphed performance informing treatment modification, whenever possible.

3.2.G ABA Treatment Plan

The ABA Treatment Plan must identify all target behaviors that are to be addressed by the ABA Stage 3 practitioners. The following elements are required in the treatment plan:

3.2.G(1) Must be completed as expeditiously as possible, but no later than two months after the completion of the 97151 and be updated prior to the end of the eligible recipient's Prior Authorization period.

3.2.G(2) Address the maladaptive behavior(s), skill deficit(s), and symptom(s) that present a safety risk to self or others or prevent the eligible recipient from adequately participating in home, school, and community activities, which may necessitate planned collaboration with an ABA Specialty Care Provider;

3.2.G(3) Include a goal of working with the Family Set of the eligible recipient in order to assist with the acquisition, maintenance, and generalization of functional skills;

3.2.G(4) Incorporate strategies for promoting generalization and maintenance of the goal's behavior change with the eligible recipient's Family Set;

3.2.G(5) Specify location(s) where services are delivered (e.g., home or clinic) in each ABA Stage 3 Service Authorization - initial and ongoing - and in the ABA Treatment Plan; take into account all school or other community resources available to the eligible recipient, provide evidence that the requested ABA Stage 3 services are not redundant with other services already being provided or otherwise available, and coordinate therapies (e.g., from school and special education), with other interventions and treatment (e.g., speech, occupational therapy, physical therapy, individual and family outpatient counseling, and medication management, both physical and behavioral health);

3.2.G(6) Include other interventions and treatment; (e.g., speech therapy, occupational therapy, physical therapy, family counseling, medical, and medication management - both behavioral health and physical health);

3.2.G(7) Be signed by the BA/Mentored BA responsible for ABA Treatment Plan development and oversight of its implementation by one or more BAAs or BTs, if services are not implemented by the BA/Mentored BA directly;

3.2.G(8) Be time-limited such that the ABA Treatment Plan can be executed within the Prior Authorization period with ongoing Prior Authorization requests during the approved Service Authorization period, continue to be diagnosed with ASD, and with the understanding from the MCO or TPA that clear and compelling positive behavior change from comprehensive intervention services may not be observed following the initial and possible next Prior Authorization period;

3.2.G(9) Be recipient-centered, Family Set-focused, and minimally intrusive, with a focus on family engagement, training, and support; if members of the Family Set cannot face-to-face attend the eligible recipient's sessions, then other opportunities must be explored, such as the members of the Family Set participating via telemedicine (in real-time or through store-and-forward means);

3.2.G(10) Be specific and individualized to the eligible recipient, with clear identification and description of the target behaviors and symptoms;

3.2.G(11) Include objective data on the baseline level of each target behavior/symptom in terms of directly observed and measured frequency, rate, latency, or duration, and include scores and interpretation from criterion-referenced, norm-referenced, and/or standardized assessment tools (e.g.,

The Verbal Behavior Milestones Assessment and Placement Program [VB-MAPP], The Assessment of Basic Language and Learning Skills-Revised [ABLLS-R]), as applicable;

3.2.G(12) Include a comprehensive description of interventions and intervention procedures specific to each of the targeted behaviors/symptoms, including documentation of approximately how many service units will be allocated to each;

3.2.G(13) Establish treatment goals and objective measures of progress on each goal specified to be accomplished in the eligible recipient's Prior Authorized period;

3.2.G(14) Incorporate strategies for promoting generalization and maintenance of behavior change; and

3.2.G(15) Offer measurable discharge criteria and discharge planning that begins the first date of ABA Stage 3 services. Generally an eligible recipient is discharged when: (1) symptoms related to ASD have been remediated; 2) symptoms related to ASD no longer cause clinically significant impairment, resulting in functional limitations that constitute a barrier to quality of life; 3) Symptoms no longer interfere significantly with home, community, and age-appropriate activities.

3.3 ABA STAGE 2 AND 3 CONSIDERATIONS

ABA Treatment Plan must be rendered in accordance with the eligible recipient's ABA Treatment Plan and within any identified constraints associated with the request for Prior Authorization of services.

3.3.A Throughout all phases of ABA treatment, including Stage 3 delivery of treatment, the BA/Mentored BA is ultimately responsible for ensuring that the following essential practice elements are apparent:

1. Behavior and Functional Analytic Assessment describing specific levels of behavior at baseline and informs subsequent establishment of ABA treatment goals;
2. An emphasis on understanding the current and future value (or social importance) of behavior(s) targeted for treatment;
3. A practical focus on establishing small units of behavior which build towards larger, more significant changes in functioning related to improved health and levels of independence;
4. Collection, quantification, and analysis of direct observational data on behavioral targets during treatment and follow-up to maximize and maintain progress toward treatment goals;
5. Efforts to design, establish, and manage the social and learning environment(s) to minimize problem behavior(s) and maximize rate of progress toward all goals;
6. An approach to the treatment of problem behavior that links the function of (or the reason for) the behavior to the programmed intervention strategies;
7. Use of a carefully constructed, individualized and detailed behavior or functional analytic assessment to develop the ABA Treatment Plan that utilizes reinforcement and other behavioral principles and excludes the use of methods or techniques that lack consensus about their effectiveness based on evidence in peer-reviewed publications;
8. Use of treatment that is implemented repeatedly, frequently, and consistently across environments until discharge criteria are met;
9. An emphasis on ongoing and frequent direct assessment, analysis, and adjustments to the **97151** and **T1026 UD** Clinical Management, **97155** and **97158** to the ABA Treatment Plan based on the eligible recipient's progress as determined by observations and objective data analysis;
10. An emphasis on ongoing and frequent case supervision of the Mentored BA/BAA/BT rendering ABA Stage 3 services to the eligible recipient;
11. Direct support and training of the eligible recipient's Family Set members, and other involved professionals to promote optimal functioning, generalization, and maintenance of behavioral improvements; and
12. A comprehensive infrastructure for clinical management and case supervision of all assessment and treatment by a BA/Mentored BA/BAA/BT.
13. A record must be maintained by the AP agency and, as appropriate, the ABA SCP for each recipient. Records for **0362T** and **0373T** must be placed in the AP agency's recipient record.

14. All copies of CDE (**T1026 TG**) or Targeted or Risk Evaluation (**T1026 HK**), ISP (**T1026 TG/HI**), ISP update (**T1026 HK/HI**), and **97151** and ABA Treatment Plans, along with updates to the aforementioned documents, must be maintained as part of the eligible recipient's record by the AP agency.
15. A contact log which documents the delivery of all billable services (including Case Supervision and Clinical Management activities), as well as all clinically significant non-billable services, must be maintained.
16. Each ABA Stage 3 session must be documented by a progress note and as appropriate, graphing. The note must include the date of service, the time and duration of service, location/setting, the practitioner(s) present during the delivery of service, parent or caregiver present, and the clinical content of the session, quantitative data to support the clinical content, and a plan for the next visit. Progress notes must be signed by the practitioner and the supervising BA/Mentored BA/BAA unless the service is rendered by the supervise themselves, in which case only their signature is required. The eligible recipient's Family Set member's signature is not required by MAD.
17. An ABA Treatment Plan Update and Progress Report must be prepared and submitted to the MCO or TPA prior to the end of the eligible recipient's Prior Authorization period and maintained as part of the eligible recipient's record.

**3.4 Billing Instructions for ABA Stage 2
No Prior Authorization Required**

Location of ABA Stage 2 Services

MAD supports the delivery of ABA Stage 2 services in the eligible recipient's home, alternative living arrangement, clinic, respite care or community-based setting, educational or vocational settings as appropriate.

In order to develop an ABA Stage 3 treatment plan, the BA/Mentored BA may be required to observe the eligible recipient in a variety of situations, such as in their home, school, clinic, or out in the community.

When Indirect **97151**, such as a BCBA interviewing a member of the Family Set, and a RBT/BCAT is rendering **97152**, both services may be billed same day-same time.

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| 97151 | BA Mentored BA | <p><u>ABA Stage 2 Behavior or Functional Analytic Assessment</u></p> <p>A Specialty Care Practitioner (SCP) does not bill 97151 or 97152; instead, bills 0362T for assessment and 0373T for treatment planning.</p> <p>BA/Mentored BA gathers data, observes and analyzes scores/interprets assessments, and interviews recipient's Family Set which are then incorporated into a Behavior or Functional Analytic Assessment Report and the results are used to develop the ABA Stage 3 Treatment Plan.</p> <p>97151 allows both direct and indirect activities for a BA/Mentored BA.</p> <p>Maximum number of units per 97151: When the AP agency employs only BCBA's and no BTs, the maximum units is forty 15-minute units or ten hours. For agencies that employ a BAA or BT</p> |
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| | <p>who would render 97152, the maximum number of units 97151 is twenty-four 15-minute units or six hours.</p> <p>If the recipient is an adult presenting with complex issues or extensive history of treatment, the maximum units is eighty 15-minute units or twenty hours.</p> <p>A BA/Mentored BA must conduct 97151 at least annually or as medically warranted for each recipient without Prior Authorization.</p> <p>Direct 97151 is for the actual assessment is conducted. Cannot be delivered through telemedicine.</p> <p>Indirect 97151 is when scoring and analyzing assessment results, interviewing recipient’s Family Set, customizing the completing Behavior or Functional Analytic Assessment Report and the ABA Stage 3 Treatment Plan.</p> <p>Indirect 97151 is billed when the BA/Mentored BA must customize the eligible recipient’s environment and materials to conduct 0362T.</p> <p>When the BA/Mentored BA directs a BAA to render Indirect 97151, the BAA bills under the BA’s/Mentored BA’s 1st Modifier when the BAA:</p> <ul style="list-style-type: none"> • Interview members of the eligible recipient’s Family Set; • Scores the results of 97151, 97152 and 0362T. <p>A BA/Mentored BA conducts 97151 at any point during the eligible recipient's Service Authorization without a Prior Authorization when the BA/Mentored BA determines it is medically warranted. The medical necessity must be documented in the eligible recipient's clinical file.</p> <p>When the BA/Mentored BA reaches out to a SCP to conduct a functional assessment to determine if Specialty Care services are medically warranted, the SCP bills 0362T and 0373T instead of 97151. The medical necessity must be documented in the eligible recipient’s clinical file.</p> <p>A BA/Mentored BA bills Indirect 97151 and Q3014 when conducting interviews or discussing the Treatment Plan or Protocols with the Family Set delivered via telemedicine.</p> <p><u>CMS Medicaid NCCI MUE limits:</u> 97151 to eight 15-minute units or two hours per day.</p> <p><u>Exceeding Medicaid MUE Limits:</u> Under the following circumstances, a BA/Mentored BA may exceed the CMS Medicaid NCCI MUE limits when billing 97151.</p> |
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| | | <ol style="list-style-type: none"> 1. The eligible recipient travels in excess of two hours one-way to complete 97151 by the BA/Mentored BA. 2. The eligible recipient poses a danger to self or others when traveling outside their home to participate in 97151. 3. The scope of the assessment and length of time necessary to conduct the assessment exceeds eight 15-minute units and would necessitate the eligible recipient returning the next day to complete or continue the assessment. 4. The BA/Mentored BA has determined the eligible recipient is able to attend in meaningful ways more than eight 15-minute units of one assessment or multiple assessments that would prevent the eligible recipient and Family Set member from having to return another day to complete the assessment(s). <ul style="list-style-type: none"> • Bill under the directing BA's/Mentored BA's corresponding 1st modifier. • Bill up to eight 15-minute units of 97151 on separate claim lines. <p><u>Concurrent Billing:</u> 97152 when rendered by a separate practitioner <u>In Conjunction with 97151:</u> 97152 0362T 97156 and 97157 while the eligible recipient's initial Behavioral/Functional Analytic Assessment has been scheduled, and when 97151 being conducted Q3014 for Indirect 97151 functions</p> <ul style="list-style-type: none"> • When the BA/Mentored BA is conducting annual or a medically warranted 97151, all Stage 3 services continue as Prior Authorized. <p><u>Do Not Bill:</u> Q3014 for Direct 97151 assessment 0373T</p> |
| NEW | <p style="text-align: center;">BA Mentored BA BAA RBT/BCAT</p> | <p><u>ABA Stage 2 – 97152 - Supporting Assessment to 97151</u></p> <p>A SCP does not bill 97152; instead bills 0362T. 97151 must be in process to bill 97152.</p> <p>A BA/Mentored/BA bills 97152. A SCP bills 0362T, as the eligible recipient's presentation requires either practitioner or two or more.</p> <p>Maximum number of units per 97152: Thirty-two 15-minute units or eight hours.</p> <p>The BA/Mentored BA directs the work of one BAA/RBT/BCAT to render supporting assessments for the BA/Mentored BA who completes the Behavior or Functional Analytic Assessment Report. If the BA/Mentored BA determines the need for a supporting</p> |

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| | | <p>assessment requiring two or more BAs/Mentored BAs/BAA/RBTs/BCATs present, see 0362T. The BAA/RBT/BCAT bills under the BA's/Mentored BA's 1st Modifier.</p> <p>97152 is billed at any point without Prior Authorization during the eligible recipient's Service Authorization when the BA/Mentored BA determines it is medically warranted. The medical necessity must be documented in the eligible recipient's clinical file. A BA/Mentored BA must be conducting 97151 to bill 97152.</p> <p>Bill 97151 when incorporating the findings of 97152 into the final Behavioral or Functional Analytic Assessment Report by the BA/Mentored BA.</p> <p>If the Mentored BA/BAA/RBT/BCAT does not have the expertise to render a specialized 97152 assessment, the BA/Mentored BA may bill T1026 UD Case Supervision to provide specific training to the practitioners listed above that are not included in their BACB or BICC certification requirements and are unique to the eligible recipient's 97152. T1026 UD Case Supervision cannot include time spent instructing a Mentored BA/BAA/RBT/BCAT on skills or training related to their BACB or BICC certification. MAD considers these non-reimbursable supervision requirements necessarily to the practitioner gaining and retaining BACB or BICC certification.</p> <p><u>CMS Medicaid NCCI MUE limits:</u> 97152 to eight 15-minute units or two hours per day.</p> <p><u>Exceeding Medicaid MUE Limits:</u> Under any of the following circumstances, a BA/Mentored BA may exceed the CMS Medicaid NCCI MUE limits of eight 15-minute units or two hours.</p> <ol style="list-style-type: none"> 1. The eligible recipient travels in excess of two hours one-way to be assessed by the BA/Mentored BA; or 2. The eligible recipient poses a danger to self or others when traveling outside their home or community to participate in the ABA Stage 2 97152 regardless of the travel distance; or 3. The scope of the assessment and length of time necessary to conduct 97152 exceeds eight 15-minute units and would necessitate the eligible recipient returning the next day to complete or continue the assessment. 4. The BA/Mentored BA has determined the eligible recipient is able to attend in meaningful ways more than eight 15-minute units of one assessment or multiple assessments that would prevent the eligible recipient from having to return another day to complete the assessment(s). <p>Bill 97152 under the directing BA's/Mentored BA's corresponding 1st Modifier.</p> |
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| | | <p>Bill up to thirty-two 15-minute units or eight hours of 97152 on separate claim lines in total.;</p> <p><u>Concurrent Billing:</u> Indirect 97151 when rendered by a separate practitioner.</p> <p><u>In Conjunction with 97152:</u> 97151 0362T 97156 and 97157 while the eligible recipient’s initial Behavioral/Functional Analytic Assessment has been scheduled and when 97152 is being conducted.</p> <ul style="list-style-type: none"> • When the BA/Mentored BA is conducting the annual (not the initial) or medically warranted 97152 during the Service Authorization or during the EPSDT or Adult Grace Period Prior Authorization, all Stage 3 services continue as Prior Authorized. <p><u>Do Not Bill:</u> 0373T Q3014</p> |
| <p>0362T</p> | <p>SCP</p> <p>BA</p> <p>Mentored BA</p> <p>BAA</p> <p>RBT/BCAT</p> | <p><u>ABA Stage 2 Supporting Assessment to 97151 with 2 or More BAs/BAA/RBTs/BCATs</u></p> <p>The BA/Mentored BA must be in the process of completing 97151 to bill 0362T. The SCP must be in the process of completing 0373T Specialty Care treatment protocols to bill 0362T.</p> <p>A BA/Mentored/BA bills 97152 A SCP bills 0362T, as the eligible recipient’s presentation requires two or more practitioners.</p> <p>Maximum number of units per 0362T up to forty-15 minute units or ten hours. The BA/Mentored BA/SCP directs the work of two or more BAs/Mentored/BAs/BAA/BTs having the expertise to render supporting behavior or functional assessments for the BA/Mentored BA/SCP to complete a Behavior or Functional Analytic Assessment.</p> <p>0362T may be billed at any point during the eligible recipient's Service Authorization without Prior Authorization when the BA/Mentored BA determines it is medical necessity to complete 97151 or the SCP determines the need for 0362T and 0373T. The medical necessity must be documented in the eligible recipient's clinical file.</p> <p><u>To bill 0362T the following must all be met:</u></p> <ol style="list-style-type: none"> 1. Directed by the BA/Mentored BA/SCP who is onsite (meaning immediately available and interruptible). |

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| | | <p>2. BA/Mentored BA/SCP is closely monitoring two or more BAs/Mentored BAs/BAA/RBT/BCAT implementation of the supporting assessments, providing corrective feedback when needed.</p> <p>3. The eligible recipient is exhibiting serious dangerous or destructive behavior that requires more than one BA/Mentored BA/BAA/RBT/BCAT be present.</p> <p>The BA/Mentored BA configures a safe customized environment to render 0362T based on the eligible recipient’s serious dangerous or destructive behaviors. The SCP bills 0373T instead. 0362T cannot be rendered in the eligible recipient’s home; must be rendered in a customized center or clinic setting.</p> <p>Prior to rendering 0362T, the BA/Mentored BA/SCP utilizes 0362T to further explore specific behaviors using two or more BAs/Mentored BAs/BAA/RBTs/BCATs to render the supporting functional assessments the BA/Mentored BA/SCP determined is medically warranted in order to develop an ABA Stage 3 Treatment Plan or ABA Specialty Care Treatment Protocols.</p> <p>Billing 97151, the BA/Mentored BA completes a Risk Assessment (not a <i>T1026 HK-Risk Evaluation</i>) to determine the safeguards necessary to conduct a safe functional analysis, then reviews with BAs/Mentored BAs/BAA/BAA/BBT/BCATs how to safely implement the supporting assessment in the eligible recipient’s customized environment and develops any materials necessary for the supportive assessment. The SCP bills 0373T instead.</p> <p>Billing 97151, the BA/Mentored BA analyzes, scores, and interprets the results of the findings of 0362T. A SCP bills 0373T instead and if under the direction of the SCP, a BA/Mentored BA may score 0362T billing 0373T under the SCP’s 1st Modifier.</p> <p>If a BA/Mentored BA/BAA/RBT/BCAT does not have the expertise to render 0362T, the BA/Mentored BA bills T1026 UD Case Supervision to provide specific training to the BA/Mentored BA/BAA/RBT/BCAT that is not included in their BACB or BICC certification requirements. A SCP bills 0373T under such occurrences.</p> <p>T1026 UD does not include time spent instructing a BA/Mentored BA/BAA/RBT/BCAT on skills required for their BACB or BICC certification. Such time is not reimbursable by MAD and MAD considers it part of the BACB’s or BICC’s supervision requirements.</p> <p><u>CMS MUE Limits:</u> CMS Medicaid NCCI MUE limits 0362T to eight 15-minute units or two hours per day.</p> |
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| | | <p><u>Exceeding Medicaid MUE Limits:</u> Under any of the following circumstances, a BA/Mentored BA/SCP may exceed the CMS Medicaid NCCI MUE limits of eight 15-minute units or 2 hours.</p> <ol style="list-style-type: none"> 1. The eligible recipient travels in excess of two hours one-way to be assessed by the BA/Mentored BA/SCP. 2. The eligible recipient poses a danger to self or others when traveling outside their home or community to participate in the assessment. 3. The scope of the assessment and length of time necessary to conduct the assessment exceeds eight 15-minute units and would necessitate the eligible recipient returning the next day to complete or continue the assessment. 4. The BA/Mentored BA/SCP has determined the eligible recipient is able to attend in meaningful ways more than eight 15-minute units of one assessment or multiple assessments that would prevent the eligible recipient from having to return another day to complete the assessment(s). <p>Bill 0362T under the directing BA's/Mentored BA's/SCP's corresponding 1st modifier.</p> <p>Bill up to eight 15-minute units of 0362T on separate claim lines, not to exceed thirty-two 15-minute units or eight hours in total.</p> <p><u>Concurrent Billing:</u> NONE</p> <p><u>In Conjunction with 0362T:</u> 97151 except SCP 97152 except SCP 97156 and 97157 while the eligible recipient's initial Behavioral/Functional Analytic Assessment has been scheduled and when 0362T is being conducted.</p> <p>T1026 Indirect UD Case Supervision except SCP 0373T -only SCP</p> <ul style="list-style-type: none"> • When the BA/Mentored BA is conducting the annual (not initial) or medically warranted 0362T, the eligible recipient continues all Stage 3 services as Prior Authorized. <p><u>Do Not Bill:</u> Q3014</p> |
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4. ABA CLINICAL MANAGEMENT AND CASE SUPERVISION

ABA Stage 3 services require clinical management and the case supervision of Mentored BA's/BAA's/RBTs/BCATs/Non-certified BTs.

4.A Indirect T1026 Clinical Management includes when the implementation of recipient’s Treatment Plan with fidelity requires the Mentored BA/Mentored BA/BAA/BT to possess knowledge and skills beyond his or her knowledge base but does not exceed the scope of the practitioner’s practice. **T1026 UD Indirect Clinical Management** is conducted by a BA/Mentored BA/BAA.

4.B Indirect T1026 UD Case Supervision is conducted by a BA/Mentored BA/BAA. The Mentored BA’s/BAA’s supervising BA/Mentored BA provides oversight and reviews of **T1026 UD Clinical Management** to recipients under the BA/Mentored BA/BAA responsibility. **T1026 UD Indirect Clinical Management** are those activities related to review and analysis of collected data, modification of ABA Treatment Plan and Treatment Protocols, follow-up interviews with the eligible recipient’s Family Set and other agencies involved with the eligible recipient.

4.C Direct T1026 UD Case Supervision involves the BA/Mentored BA/BAA observing the Mentored BA/BAA/ BT, or the BAA observing the RBT/BCAT in his or her delivery of the Treatment Protocols either onsite with the eligible recipient, members of the Family Set or delivered through telemedicine. If a Mentored BA/BAA/BT requires additional training to render unique aspects of a specific recipient’s ABA Stage 2 or 3 services, see **Indirect T1026 UD Case Supervision**.

Several factors may be cited as justification for a short or long-term increase in **T1026 Direct/Indirect UD Case Supervision** and/or **T1026 UD Clinical Management**, including:

1. Treatment dosage/intensity;
2. Barriers to progress;
3. Issues of recipient’s health and safety (e.g., certain skill deficits, dangerous problem behavior);
4. The sophistication or complexity of treatment protocols;
5. Family dynamics or community environment;
6. Lack of progress or increased rate of progress;
7. Changes in treatment protocols;
8. Transitions with implications for continuity of care.

4.4.D BACB and BICC Supervision Requirements: The practitioner’s certifying board has its own supervision requirements for the practitioner to maintain their certification. This type of supervision not reimbursable by MAD. See each practice boards requirements as to whom may render its supervision.

4.4.E. Allowable ABA Stage 3 Services during ABA Stage 2 services

An eligible recipient may start **97156** and **97157** while the BA is completing ABA Stage 2 services. These services are not prior authorization. Opening these two services while the assessments are conducted provides the eligible recipient’s Family Set to receive guidance to support them until ABA Stage 3 services are approved. See billing instructions for ABA Stage 3 **97156** and **97157** below.

| 4.4.F Billing Instructions for ABA Stage 3 Clinical Management and Indirect/Direct Case Supervision | | |
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| T1026 2nd Modifier UD | BA Mentored BA Supervising BAA | <p><u>ABA Indirect Clinical Management and Indirect/Direct Case Supervision</u></p> <p>T1026 UD is billed in one-hour units.</p> <p>Bill partial T1026 units following directions under 1.2.A</p> |

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| | <p>Prior Authorization: NO As T1026 UD Direct and Indirect Case Supervision and Clinical Management are required in specific amounts, no Prior Authorization is required</p> <p>Indirect T1026 UD Clinical Management is reimbursed for the BA/Mentored BA/Supervising BAA (is a BAA approved by their BA) when making modifications to the treatment plan or protocols.</p> <p>Indirect and Direct T1026 UD Case Supervision is rendered at a rate that maximizes progress and allows treatment integrity issues to be addressed expediently.</p> <p>For every eighty 15-minute units or 20 hours of Stage 3 services (except for 97155) rendered, at least four 15- minute units or 1 hour of Indirect and Direct T1026 UD Case Supervision must be rendered. Of the four 15-minute units, at least two 15-minute units must be Direct T1026 UD Case Supervision and at least one 15-minute units must be Indirect T1026 UD Case Supervision. The remaining one 15-minute unit may be utilized to increase any combination of Direct T1026 UD and Indirect T1026 UD.</p> <p>Direct T1026 UD Case Supervision involves BA/Mentored BA/Supervising BAA observing the Mentored BA/BAA/BT, or the Supervising BAA observing the RBT/BCAT in their delivery of the Treatment Protocols either onsite with the eligible recipient, members of the Family Set or delivered through telemedicine. If a Mentored BA/BAA/BT requires additional training to render unique aspects of a specific recipient’s ABA Stage 2 or 3 services, see Indirect T1026 UD Case Supervision.</p> <p>Indirect Case Supervision may be billed to develop the required knowledge and skills to implement the eligible recipient’s Treatment Plan or Treatment Protocol. However, Indirect T1026 UD Case Supervision cannot be billed for the practitioner’s general continuing education to remediate knowledge, skill deficits or build competencies associated with ABA practitioner’s requirements. Content of Direct/Indirect T1026 UD Case Supervision must be differentiated from the practitioner’s certification board’s supervision requirements as Direct/Indirect T1026 UD Case Supervision is specific to an eligible recipient, not the overall delivery of services to multiple recipients.</p> <p>Indirect T1026 UD Clinical Management is rendered at the rate of at least one to two 15-minute units for every eighty 15-minute units or 20 hours of Stage 3 services (except for 97155) and is billed by BA/Mentored BA/Supervising BAA (if approved by their BA) with the BAA/BT not present. The Mentored BA’s/BAA’s Supervising BA provides oversight and review of T1026 Clinical Management to recipients under the BA/Mentored BA/Supervising BAA responsibility. Clinical Management are</p> |
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those activities related to review and analysis of collected data, modification of ABA Treatment Plan and Treatment Protocols, follow-up interviews with the eligible recipient's Family Set and other agencies involved with the eligible recipient.

Case Supervision delivered through Telemedicine

For every eighty 15-minute units or 20 hours of Stage 3 services (except for 97155) rendered, at least four 15-minute units or 1 hour of **Indirect and Direct T1026 UD Case Supervision** must be rendered. Of the four 15-minute units, at least two 15-minute units must be **Direct T1026 UD Case Supervision**.

A. Indirect T1026 UD Case Supervision delivered through Telemedicine:

1. The **BA/Mentoring BA** meeting with the BAA/BT, prior to or following the delivery of 97153, 97154 or 97156 may be rendered 100% through telemedicine.
2. The BA meeting with a Mentoring BA/Supervising BAA rendering 97157 or 97158 may be rendered 100% through telemedicine.

B. Direct T1026 UD Case Supervision delivered through Telemedicine:

Based on the newly defined scope of 97155, the face-to-face requirements and the latest research on the effectiveness of **Direct T1026 U Case Supervision** delivered 100% through telemedicine, MAD, under limited situations and limited face-to-face, is allowing most, if not all the required **Direct T1026 UD Case Supervision** be delivered through telemedicine to the following practitioners.

Mentored BA/Supervising BAA:

A Mentored BA/Supervising BAA may have 100% of their **Direct T1026 UD Case Supervision** delivered through telemedicine when the clinical record of the eligible recipient documents that the eligible recipient's presentation supports **Direct T1026 UD Case Supervision** through telemedicine.

BAA/RBT/BCAT:

1. A BAA/RBT/BCAT must have **Direct T1026 UD Case Supervision** may have 100% of their Direct T1026 UD Case Supervision delivered through telemedicine when
The clinical record of the eligible recipient documents that the eligible recipient's presentation supports **Direct T1026 Case Supervision** to be delivered through telemedicine; and
2. The personnel record of the BAA/RBT/BCAT substantiates they have the expertise to receive **Direct T1026 UD Case Supervision** delivered through telemedicine.

Non-certified BT:

Until such time as a non-certified BT is certified by the BACB or BICC, MAD requires the directions below be followed.

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| | <p>a. At a minimum, of the two 15-minute units of Direct T1026 UD Case Supervision required, 75% must be rendered onsite with the eligible recipient and non-certified BT;</p> <p>b. The remaining 25% may be delivered through telemedicine;</p> <p>c. The clinical record of the eligible recipient documents that the eligible recipient’s presentation supports Direct T1026 Case Supervision to be delivered through telemedicine; and</p> <p>d. The personnel record of the non-certified BT substantiates the non-certified BT has the expertise to receive no more than 25% of Direct T1026 UD Case Supervision delivered through telemedicine.</p> <p>e. After the non-certified BT is an RBT/BCAT, their BA/Mentored BA/Supervising BAA may determine when the newly certified RBT or BCAT is ready to receive additional Direct T1026 UD Case Supervision delivered through telemedicine.</p> <p><u>Exceptions to Direct T1026 UD Case Supervision delivered through telemedicine:</u></p> <p>A. When the location of the eligible recipient requires the BA/Mentored BA/Supervising BAA to travel 60 miles or more or the travel time is 60 minutes or more to reach the eligible recipient’s location, 100% Direct T1026 Case Supervision may be delivered through telemedicine.</p> <p>B. Additional requirements for Indirect T1026 UD Case Supervision are required (see below). The AP agency, at the start of the eligible recipient’s ABA Stage 3 services, must submit to the MCO or TPA documentation the distance between the BA’s/Mentored BA’s/Supervising BAA’s location to the eligible recipient’s location is at least one-hour one-way or 60 miles one-way.</p> <p>Additional exceptions include:</p> <p>1. When the location of the eligible recipient requires the BA/Mentored BA/Supervising BAA to travel stretches of county roads or poses challenges to accessing emergency services of over 20 minutes, an exception is approved. The BA/Mentored BA/Supervising BAA must describe the situation in the eligible recipient’s clinical file.</p> <p>2. If the location of the eligible recipient requires the BA/Mentored BA/Supervising BAA to travel on Interstate or State roads and the route poses challenges to accessing emergency services of over 20 minutes, an exception is approved. The BA/Mentored BA/Supervising BAA must describe the situation in the eligible recipient’s clinical file.</p> <p>3. When the road a BA/Mentored BA/Supervising BAA travels to access the location of the eligible recipient poses safety issues (dangerous winds/dust, severe thunderstorms, snowy or icy conditions), an exception is approved for only that cycle of supervision. The BA/Mentored BA/Supervising BAA must describe the situation in the eligible recipient’s clinical file.</p> |
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| | | <p>B. Indirect T1026 UD Case Supervision must increase at least by three 15-minute units and up to four 15-minute units in addition to the required two 15-minute units of Direct T1026 UD Case Supervision. This allows the BA/Mentored BA/Supervising BAA to have additional time to discuss and plan with the BAA/RBT/BCAT the implementation of the ABA Treatment Plan and Treatment Protocols.</p> <p>C. The BA/Mentored BA/Supervising BAA must document in the eligible recipient’s file that the use of Direct T1026 UD Case Supervision delivered through a telemedicine exception meets the needs of the family, recipient and the BAA’s/RBT’s/BCAT’s personnel record substantiates the he or she has the expertise to receive 100% Direct T1026 UD Case Supervision delivered through a telemedicine exception.</p> <p><u>Store and Forward Telemedicine Technology for Direct T1026 UD Case Supervision:</u> To increase rural and frontier ABA Stage 3 services, MAD allows under limited situations the use of Store-and-Forward telemedicine technology transmissions for 100% of ABA Stage 3 Direct T1026 UD Case Supervision. Store-and-Forward telemedicine does not occur in real time (asynchronous) and does not require a F2F live encounter with the eligible recipient and the Mentored BA/Mentored BA/BAA/RBT/BCAT and the BA/Mentored BA/Supervising BAA. This technology allows through the transference of digital images, sounds, or previously recorded video sent from the onsite practitioner to the BA/Mentored BA/Supervising BAA to obtain information, analyze it, and report back to the onsite practitioner during their Direct T1026 UD Case Supervision.</p> <p>MAD allows an AP agency to utilize Store-and-Forward telemedicine technology to provide 100% of Direct T1026 UD Case Supervision to be rendered when the following requirements are met:</p> <ol style="list-style-type: none"> 1. An AP agency must submit on an annual basis to the MCO or TPA documentation from the AP agency’s telemedicine transmission provider they it cannot provide real-time telemedicine transmissions between the eligible recipient’s location and the BA’s/Mentored BA’s/Supervising BAA’s location. This must also be documented in the eligible recipient’s clinical file. 2. Indirect T1026 UD Case Management must be increased at least by two 15-minute units or 30 minutes and up to four 15-minute units or 1 hour in addition to the required minimum two 15-minute units or 30 minutes. This would allow the BA/Mentored BA/Supervising BAA to have additional time to discuss and plan with the BAA/RBT/BCAT the |
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| | | <p>implementation of the ABA Treatment Plan and Treatment Protocols.</p> <ol style="list-style-type: none"> 3. The BA/Mentored BA/Supervising BAA must document in the eligible recipient's file that the use to Direct T1026 UD Case Supervision delivered through Store-and-Forward telemedicine technology meets the needs of the family, recipient and BAA's/RBT's/BCAT's personnel file substantiates the he or she has the expertise to receive 100% Direct T1026 UD Case Supervision delivered through Store-and-Forward telemedicine technology, and without the use of Store-and-Forward telemedicine technology the eligible recipient could not access ABA Stage 3 services. 4. A non-certified BT cannot receive Direct T1026 UD Case Supervision delivered through Store-and-Forward telemedicine technology. <p><u>Concurrent Billing:</u> Q3014 as approved</p> <p><u>In Conjunction with T1026 UD:</u> 97153 97154 97155 BA/Mentored BA/Supervising BAA (without telemedicine) 97156 rendered by a BA to a Mentored BA/BAA 97157 rendered by a BA to a Mentored BA 97158 rendered by a BA to a Mentored BA</p> <p><u>Do Not Bill:</u> 0373T</p> |
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ABA STAGE 3 IMPLEMENTATION

4.A Stage 3 Authorizations:

ABA Stage 3 services require a Service Authorization and a Prior Authorization, see 1.3. Depending on the eligible recipient's age, the Service Authorization and the Prior Authorization have different schedules. To begin ABA Stage 3 services, there must be an approved initial Service Authorization and a Prior Authorization. During the Service Authorization period, concurrent Prior Authorizations are submitted to the MCO or TPA for action. Prior Authorization requests lay out the eligible recipient's gains over the ending Prior Authorization period. For a number of recipients, it may not be so much gains; instead it may be the ability of the eligible recipient to maintain learned adaptive behaviors. Once the Service Authorization is approved, the MCO or TPA reviews the Prior Authorization request.

5.A(1) Service Authorization:

- a. For an EPSDT-aged recipient 12 months up to eight years, their Service Authorizations are three years.
- b. For an eligible recipient eight years and older, their Service Authorizations are six years.

5.A(2) Prior Authorization Period:

- a. For an eligible recipient between 12 months to eight years, the Prior Authorizations are every six months during the Service Authorization period for 97153 and 0373T.
- b. For an eligible recipient eight years and older, the Prior Authorizations are annually during the Service Authorization period for 97153 and 0373T.
- c. At any time during the Service Authorization period the eligible recipient, appropriate member of the Family Set or BA/Mentored BA may request from the eligible recipient's AEP conduct CDE **T0126 TG**, ISP (**T1026 TG/HI** Targeted or Risk Evaluation (**T1026 HK**), or ISP Update (**HK/HI**) or the BA/Mentored BA may conduct **97151** if immediate changes are warranted to preserve the health of the eligible recipient or to meet the current needs of the eligible recipient.

5.B Prior Authorization Requirements

Once an EPSDT-aged recipient has a CDE based diagnosis of ASD, or an eligible adult has been diagnosed with ASD (see 2.3B(2)(c).

1. The BA must provide the MCO or TPA the following documents in addition to the MCO's or TPA's version of the OSI Uniform Prior Authorization form:
2. Latest ABA Stage 1 Evaluation for the initial Prior Authorization request
3. Latest ABA Grace Exception Diagnosis to be submitted annually
4. Latest ABA Stage 2 Assessment to be submitted annually, and Treatment Plan for each Prior Authorization request during the eligible recipient's Service Authorization
5. Number of units requested for the eligible recipient's corresponding PA period (6 months or 12 months) for **97153** and **0373T**. No other ABA codes are prior authorized.

5.C Continuation of ABA Stage 3 Services

ABA Stage 3 services are to continue past the eligible recipient's Service Authorization when:

1. The eligible recipient continues to be diagnosed with ASD; and
2. The BA determines the eligible recipient requires medically warranted ABA Stage 3 services to maintain gains made during the last Service Authorization or to address continuing or new maladaptive behaviors.

5.D Termination of or Halt in ABA Stage 3 Services

It is MAD's expectation the eligible recipient's MCO or TPA accepts the findings and recommendation of the eligible recipient's AEP or the Grace Period Exception Practitioners for Stage 2 and 3 services are approved until such time as the eligible recipient's AEP recommends termination of or temporary halt of ABA services.

1. The eligible recipient requires a higher level of care of which ABA services are temporarily halted until the eligible recipient's presentation supports continuing ABA services by a team of their service providers, legal guardian of the eligible recipient, or as appropriate, the eligible recipient themselves.
2. If the eligible recipient is not responding positively to ABA Stage 3 services for reason(s), including but not limited to, inadequate family participation, insufficient service intensity, or issues with the goals and/or associated interventions outlined in the ABA Treatment Plan, the BA may work with the MCO Care Coordinator to address identified barriers of the member. If the eligible recipient is not a MCO member, the BA will be the lead.
 - a. Prior to termination or recommendation to halt in services, AP agency must first make every attempt internally to identify and address the lack of response. However, if the coordinated efforts of the AP agency and MCO Care Coordinator do not result in positive behavior change, the BA may request the eligible recipient's AEP:
 - i. Complete a new CDE (**T1026 TG**) and ISP (**TG/HI**);

- ii. Complete a Targeted Evaluation (**T1026 HK**) and new ISP (**TG/HI**) (when a new full CDE is not required);
 - iii. Complete a new Risk Evaluation and new Risk Report for recipients 12 months up to three years of age;
 - b. The BA may refer the eligible recipient to a SCP for increased clinical support.
 - c. The BA will provide alternative opportunities for Family Set members are not able to attend ABA Stage 3 **97156** or **97157** sessions at the agreed level.
2. If the barriers are temporary or for a short duration (one month), the BA and the eligible recipient or Family Set may agree to halt services and restart at the predetermined date.
 3. If the barriers cannot be overcome within one month, the AP agency may terminate ABA Stage 3 services to the eligible recipient to allow time for barriers to be resolved.
 - a. Unless medically warranted for immediate discharge, discharge date must be at least 30 calendar days from the date the eligible recipient or Family Set is notified in writing.
 - b. Once the eligible recipient or Family Set agrees to restart services, the BA will complete ABA Stage 2 services and submit a new ~~6-month~~ prior authorization for **97153** and **0373T**.
 - c. If the length of time the eligible recipient was not receiving services is past the eligible recipient's last Service Authorization period, a new Service Authorization is to be submitted with the new prior authorization.
 - d. The AP agency is not obligated to accept the eligible recipient back after they were terminated; instead, the AP agency may refer the eligible recipient to another AP agency.

5.E Billing Instructions for ABA Stage 3

Adult Stage 3 Services - In recognition of the length of time an adult recipient may access ABA services, the number of changes an adult will encounter in the course of their adult lives, and as many adults are entering into ABA services for the first time with patterns of behaviors learned over time, MAD is authorizing additional units and waivers of Prior Authorization in order to keep an adult recipient in their home and community.

Maximum units of ABA Stage 3 services take precedence overstated limits.

TIER ONE – Adult ABA Tier One Criteria – Maintenance Services

For adult recipients who require ABA services in reduced amounts to assist the eligible recipient to maintain their positive behaviors that continue to be stabilized due to continued ABA services or gains made in Adult ABA Tier Two or Three services. Adult ABA Tier One services support an eligible recipient to reduce utilization of Tier Two and Three services. An adult recipient meeting the criteria for Adult ABA Tier One has a maximum number for units for **97153**, **97154**, and **97158** combined service codes from 40 to 60 15-minute units or 10 to 15 hours per week. The service codes for **97155**, **97156**, **97157** and **T1026 UD** are not included in the maximum number of hours. See each service code below for maximum units.

TIER TWO – Adult ABA Tier Two Criteria – Intervention Services

For adult recipients experiencing life events that disrupt their normal life qualify for Adult ABA Tier Two services. Tier Two is appropriate for an adult recipient who has skill deficits across multiple domains and requires a higher dosage of treatment to ensure continuity across multiple settings, caregivers, etc. to improve treatment outcomes. Events include and are not limited to:

- Illness of self or caregiver resulting in the eligible recipient's adaptive coping responses becoming maladaptive;
- Multiple service settings and multiple staff or caregivers, such as an eligible recipient who is residing in a residential setting, has day habilitation, and interactions with parents.

- Movement from current living situation to a new living situation, thus disrupting their patterns of daily resulting in the eligible recipient's adaptive coping responses becoming maladaptive:
- Addition of new services that introduce new expectations or new staff that disrupt their patterns of daily living resulting in the eligible recipient's adaptive coping responses becoming maladaptive.

Under most situations an adult recipient will re-enter Adult ABA Adult Tier One services. An adult recipient meeting the criteria for Adult ABA Tier Two has a maximum number of units for **97153, 97154** and **97158** combined service codes from 80 to 120 15-minute units or 20 to 30 hours per week for up to six weeks without Prior Authorization. The service codes for **97155, 97156, 97157** and **T1026 UD** are not included in the maximum number of hours. See each service code below for maximum units.

TIER THREE – Adult ABA Tier Three Criteria -High-Risk Intervention Services

For adult recipients experiencing destructive or self-injurious behavior, or behavior injurious to others, resulting in the eligible recipient's adaptive coping responses becoming maladaptive such as the eligible recipient possibility accessing emergency room services, inpatient services, or incarceration. Accessing Adult ABA Tier Three services does not necessarily require the eligible recipient to first access Adult ABA Tier Two services. After Adult ABA Tier 3 services, an eligible recipient under most situations will enter Adult ABA Tier Two services. An adult recipient meeting the criteria for Adult ABA Tier Three has a maximum number of units for **97153, 97154** and **97158** combined service codes from 120 to 160 15-minute units or 30 to 40 hours per week for up to eight weeks without Prior Authorization. The service codes for **97155, 97156, 97157** and **T1026 UD** are not included in the maximum number of hours. See each service code below for maximum units.

Location of ABA Stage 3 Services

MAD recognizes for Stage 3 ABA treatment to be effective; it must be generalized across all-natural environments. MAD support the delivery of ABA Stage 3 in all the following natural environments:

- Home
- School
- Clinics, hospitals, outpatient services (physical and behavioral health)
- Childcare Centers
- Alternative living arrangements (such as but not limited to assisted or supportive living/housing, residential or institutional location such as ARTC/RTC/Group/TFC, nursing facilities)
- Respite care
- Day habilitation
- Vocational or other educational classes
- Community-based settings (e.g. stores, places of recreational or socialization)
- Place of work.

For example:

1. Services provided in a school under an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) do not preclude medically necessary services that are being provided across natural settings, including schools. Schools do not typically provide medically necessary treatment; they may be provided supports pursuant to a different standard (some educational benefit) for different purposes (to provide the educational curriculum) with differently credentialed providers (special education teachers and aides). ABA services are not replacing educational instruction, they are supporting the eligible recipient participate int their educational services
2. When the recipient is accessing residential living (adult and EPSDT ARTC/RTC/Group, emergency department (ED), hospital inpatient admission or even dental or vision visits they are eligible to receive ABA Stage 1 through 3 services to assist the recipient benefit from these services.

ABA Stage 3 Implementation

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| <p>97153</p> | <p align="center"> BA Mentored BA BAA RBT/BCAT Non-certified BT </p> | <p><u>ABA Stage 3 ABA Adaptive Behavior Treatment by Protocol One Recipient</u></p> <p><u>Bill in 15-minute units.</u></p> <p>Maximum number of units per 97153: forty 15-units or ten hours per day dependent upon Focus or Comprehensive approach.</p> <p>97153, 97154 and 97158 - for an adult recipient accessing: Adult ABA Tier One services a limit of forty to sixty 15-minute units or 10 to 15 hours of COMBINED 97153, 97154, and 97158 units is allowed. Adult ABA Tier Two services a limit of 80 to 120 15-minute units or twenty to thirty hours of COMBINED 97153, 97154, 97158 units is allowed. Adult ABA Tier Three services a limit of 120 to 160 15-minute units or thirty to forty hours of COMBINED 97153, 97154, 97158 is allowed.</p> <p><u>Prior Auth: Yes</u></p> <ol style="list-style-type: none"> 1. For an eligible recipient 12 months up to 8 years, six-month Prior Authorizations are required and may be submitted at any point during the three-year Service Authorization. 2. For an eligible recipient eight years and older, 12-month Prior Authorizations are required and may be submitted at any point during the six-year Service Authorization. 3. For an adult recipient accessing Adult ABA Tier Two and Three, no Prior Authorization is required for the first six or eight weeks of services. Thereafter, Prior Authorization is required. <p>The BA/Mentored BA in the eligible recipient's Prior Authorization request projects the number of 15-minute units of 97153 that will be rendered per week. If later the BA/Mentored BA determines it is medically warranted to increase the unit amount, submit a new prior authorization to increase 97153 units at any point during the Prior Authorized period.</p> <p>The practitioner F2F face to face implements the ABA Stage 3 Treatment Protocols. After each 97153 session, the practitioner records all results and provides data to the BA/Mentored BA/Supervising BAA.</p> <p>The practitioner cannot bill 97155 or Direct T1026 UD when they are directly rendering 97153.</p> <p>97153 cannot be delivered through telemedicine. The practitioner must be physically present with the eligible recipient.</p> |
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| | | <p><u>CMS Medicaid NCCI MUE limits:</u> 97153 to thirty-two 15-minute units or 8 hours per day.</p> <p><u>Exceeding Medicaid MUE Limits:</u> Under the following circumstances, a practitioner may exceed the CMS Medicaid NCCI MUE limits of thirty-two 15-minute units or eight hours by billing no more than thirty-two 15-minute units or eight hours on one claim line.</p> <ol style="list-style-type: none"> 1. When during a 97153 session, the eligible recipient's presentation requires immediate interventions that may result in an excess of thirty-two 15-minute units or eight hours of 97153 services for the day: 2. The practitioner may render up to forty 15-minute units or 10 hours of 97153 per event when medically warranted. 3. For an adult recipient accessing Adult ABA Tiers One through Three, see Adult ABA Tiers One through Three (above) for a detailed description of limits. 4. The rationale and resolution for the use of the additional 97153 units must be documented in the eligible recipient's clinical file. 5. The BA/Mentored BA must concur and document in the eligible recipient's clinical file that the additional units were medically warranted. 6. Use separate claim lines for the remainder of 97153 rendered. <p>A BA/Mentored BA/Supervising BAA may bill 97155 when the Mentored BA/BAA/BT bills 97153. The practitioner cannot bill 97155 when he or she is directly rendering 97153. The originating site may bill Q3014 when 97155 is delivered through telemedicine as approved.</p> <p>Prior to rendering 97153, the BA/Mentored BA/Supervising BAA may bill Indirect T1026 UD with the rendering practitioner to review the treatment targets, recipient's responses to changes in routines and responses to the unavailability of preferred items in the eligible recipient's Treatment Protocol.</p> <p>Prior to rendering 97153, the BA/Mentored BA/Supervising BAA may use Indirect T1026 UD Case Supervision to review the results of any changes with the Mentored BA/BAA/BT based on the results of the BA's/ Mentored BA's/Supervising BAA's Indirect T1026 UD Clinical Management when there is a modification in a Treatment Protocol or ABA Stage 3 Treatment Plan.</p> <p>After 97153, the BA/Mentored BA/Supervising BAA may bill Indirect T1026 UD Clinical Management to analyze the graphed data collection and results, and if needed, modify the Treatment Protocol or ABA Stage 3 Treatment Plan.</p> |
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| | | <p><u>Concurrent Billing to 97153:</u> 97155 A Mentored BA/BAA/BT may bill 97153 and their BA/Mentored BA may bill 97155 when the BA/Mentored BA is modifying a treatment protocol and both services are concurrently rendered.</p> <p><u>In conjunction with 97153:</u> 97154 97156 97157 97158 Indirect T1026 UD Case Supervision or Clinical Management</p> <ul style="list-style-type: none"> When the BA/Mentored BA is conducting the annual or medically warranted 97151, 97152, 0362T or a SCP is conducting 0362T to determine if 0373T is medically warranted, an eligible recipient may continue 97153 as approved. <p><u>Do Not Bill:</u> Direct T1026 UD Case Supervision Q3014 97155 if the BA/Mentored BA/Supervising BAA is directly rendering the service</p> |
| <p>97154</p> | <p>BA Mentored BA BAA RBT/BCAT Non-certified BT</p> | <p><u>ABA Stage 3 ABA Group Adaptive Behavior Treatment by Protocol</u></p> <p>The BA/Mentored BA/BAA/BT implements the treatment protocols and data collection procedures with the eligible recipients in a group setting. Sessions are designed to provide multiple planned opportunities for the eligible recipients to practice their individualized targeted skills. A group is constructed of two to six recipients, to include non-Medicaid recipients.</p> <p>Maximum number of units per 97154: twelve 15-minute units per week dependent upon Focus or Comprehensive approach.</p> <p>97153, 97154 and 97158 - for an adult recipient accessing: Adult ABA Tier One services a limit of forty to sixty 15-minute units or 10 to 15 hours of COMBINED 97153, 97154, and 97158 units is allowed. Adult ABA Tier Two services a limit of 80 to 120 15-minute units or twenty to thirty hours of COMBINED 97153, 97154, 97158 units is allowed. Adult ABA Tier Three services a limit of 120 to 160 15-minute units or thirty to forty hours of COMBINED 97153, 97154, 97158 is allowed.</p> <p><u>Bill in 15-minute units.</u></p> <p><u>Prior Auth: NO</u></p> |

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| | <p><u>CMS Medicaid NCCI MUE limits:</u> 97154 up to twelve 15-minute units or three hours per day.</p> <p><u>Exceeding Medicaid MUE Limits:</u> For an adult recipient accessing Adult ABA Tier Two or Three services a practitioner may exceed the CMS Medicaid NCCI MUE limit by billing no more than twelve 15-minute units or three hours on one claim line.</p> <p>When during a 97154 session, the eligible recipient's presentation requires immediate interventions that may result in an excess of twelve 15-minute units or three hours of 97154 services for the day:</p> <ol style="list-style-type: none"> 1. The practitioner may render up to sixteen 15-minute units or four hours of 97153 per event. 2. For an adult recipient accessing Adult ABA Tier Two or Three, see Adult ABA Tier Two or Three above for a detailed description of limits. 3. The rationale and resolution for the use of the additional 97154 units must be documented in the eligible recipient's clinical file. 4. The BA/Mentored BA must concur and document in the eligible recipient's clinical file that the additional units were medically warranted. 5. Use separate claim lines for the remainder of 97154 rendered. <p>A BA/Mentored BA/Supervising BAA bills 97155 when the Mentored BAA/BAA/BT bills 97153. The practitioner cannot bill 97155 when they are directly rendering 97153. The originating site may bill Q3014 when 97155 is delivered through telemedicine, as approved.</p> <p>97154 cannot be delivered through telemedicine. The BA/Mentored BA/BAA/BT must be physically present with the group members.</p> <p>A BA/Mentored BA/Supervising BAA may render 97155 when the Mentored BA/BAA/BT is billing 97154. The practitioner cannot bill 97155 or Direct T1026 UD Case Supervision when they are directly rendering 97154.</p> <p>Prior to rendering 97154, the BA/Mentored BA may bill Indirect T1026 UD Clinical Management for the BA/Mentored BA to review the treatment targets, recipient's responses to changes in routines and responses to the unavailability of preferred items in the eligible recipient's group Treatment Protocols.</p> <p>Prior to rendering 97154, the BA/Mentored BA/Supervising BAA may bill Indirect T1026 UD Case Supervision for the BA/Mentored BA/BAA to review the results of any changes based on the results of the BA's/Mentored BA's/Supervising BAA</p> |
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| | | <p>T1026 UD Clinical Management when there is a modification in a group Treatment Protocol or ABA Stage 3 Treatment Plan.</p> <p>After 97154, the BA/Mentored BA/Supervising BAA may bill Indirect T1026 UD Clinical Management to analyze the graphed data collection and results, and if needed, modify the ABA individual or group Treatment Protocols or ABA Stage 3 Treatment Plan. The BA/Mentored BA/Supervising BAA may bill Indirect T1026 UD Case Supervision to discuss changes with Mentored BA/BAA/BT.</p> <p><u>Concurrent Billing 97154:</u> 97155</p> <p><u>In Conjunction with 97154:</u> Indirect T1026 UD Case Supervision and Clinical Management 97153 97156 97157 97158</p> <p>When the BA/Mentored BA/Supervising BAA is conducting the annual or medically warranted 97151, 97152, 0362T or a SCP is conducting 0362T to determine if 0373T is medically warranted, an eligible recipient may continue 97154.</p> <p><u>Do Not Bill:</u> Direct T1026 UD Case Supervision Q3014 97155 if the BA/Mentored BA/Supervising BAA is directly rendering the service</p> |
| <p>97155</p> <p><i>Replacing 0368 T and 0369T</i></p> | <p>BA</p> <p>Mentored BA</p> <p>Supervising BAA</p> | <p><u>ABA Stage 3 Adaptive Behavior Treatment by Protocol Modification -</u></p> <p>97155 is designed to evaluate the effectiveness of the treatment plan and recipient's response to treatment. 97155 is utilized when the BA/Mentored BA/Supervising BAA is rendering the service either present with the eligible recipient and Mentored BA/BAA or BT or delivered through telemedicine where the BA/Mentored BA/Supervising BAA solves at least one problem and may, at the same time direct the Mentored BA/BAA/BT and a member of the Family Set in how to implement the new or revised Treatment Protocols. The eligible recipient must be present during the session, including the time instructions are provided to the Mentored BA/BAA/BT and Family Set. Direct T1026 UD Case Supervision is different as it evaluates the effectiveness of the practitioner rendering one of the ABA Stage 2 and 3 services.</p> <p><u>Bill in 15-minute units.</u></p> <p><u>Prior Auth: NO</u></p> |

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| | <p>As 97155 is required in specific amounts, no prior authorization is required. If medically warranted, additional units may be requested.</p> <p>For an adult recipient accessing Adult ABA Tier Two and Three, for the first 6 or eight weeks of services, the eligible recipient may receive units in excess of those listed below.</p> <p>At least four 15-minute units or one hour of 97155 must be rendered for every eighty 15-minute units or 20 hours of combined 97153, 97154 and 97158 including those codes authorized to be rendered by a Mentored BA/Supervising BAA.</p> <ol style="list-style-type: none"> 1. BA/Mentored BA/Supervising BAA directs treatment with the eligible recipient and Mentored BA/BAA/BT by observing changes in the eligible recipient’s behavior or troubleshooting Treatment Protocols. Under this situation 97155 may be delivered through telemedicine with the originating site billing Q3014. 2. BA/Mentored BA/Supervising BAA joins in person the eligible recipient to direct the Mentored BAA’s/BAA’s/BT’s implementation of a new or modified Treatment Protocol. Under this situation, 97155 may not be delivered through telemedicine as the eligible recipient and BA/Mentored BA/Supervising BAA are in the same location. <p><u>CMS Medicaid NCCI MUE limits:</u> 97155 up to twenty-four 15-minute units or 6 hours per day. An adult recipient accessing Adult ABA Tier Two or Three services may receive additional 97155 services as medically warranted and documented in the eligible recipient’s clinical record. If the units exceed twenty-four 15-minute units, bill no more than this amount per claim line.</p> <p><u>When to bill 97155 or Direct T1206 UD</u> Bill 97155 when the focus of the BA/Mentored BA/Supervising BAA is on the eligible recipient’s responses to Treatment Protocols.</p> <p>Bill Direct T1026 UD Case Supervision when the focus is on how the Mentored BA/BAA/BA renders a Treatment Protocol.</p> <p>The BA/Mentored BA/Supervising BAA must select the code that best describes the service as either Direct T1026 UD Case Supervision or 97155.</p> <p>However, during a session with the eligible recipient present, the BA/Mentored BA/Supervising BAA may render at different times during the session 97155 and T1026 UD Case Supervision– but not concurrently.</p> <p><i>Example:</i></p> |
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| | <ol style="list-style-type: none"> 1. From 10 AM to 10:30 AM, the BA bills two 15-minute units of 97155 and the BT bills two 15-minute units of 97153 or 97154. 2. From 10:45 AM to 11:15 AM, the BA/Mentored BA/Supervising BAA bills two 15-minute units of Direct T1026 UD Case Supervision. The BT does not bill 97153 or 97154 for this time period. 3. The eligible recipient’s clinical record must contain documentation differentiating between 97155 and Direct T1026 UD Case Supervision when both are rendered during one session. 4. If 97155 (as allowed) or Direct T1026 UD Case Supervision or both are delivered through telemedicine as approved, the originating site bills Q3014. <p>Prior to rendering 97155, the BA/Mentored BA may bill Indirect T1026 UD Clinical Management for the BA/Mentored BA to review the current treatment targets, recipient’s responses to changes in routines or Treatment Protocols and responses to the unavailability of preferred items in the eligible recipient’s Treatment Protocols.</p> <p>Prior to rendering 97155, the BA/Mentored BA/Supervising BAA may bill Indirect T1026 UD Case Supervision with the Mentored BA/BAA/BT to review the results of any changes based on the results of a modification in a group Treatment Protocol or ABA Stage 3 Treatment Plan.</p> <p>After 97155, the BA/Mentored BA may bill T1026 UD Indirect Clinical Management to analyze the graphed data collection and results, and if needed, modify the individual or group Treatment Protocols or ABA Stage 3 Treatment Plan. The BA/Mentored BA/Supervising BAA may bill Indirect T1026 UD Case Management to discuss changes with the Mentored BA/BAA/BT.</p> <p><u>Concurrent Billing of 97155:</u></p> <p style="padding-left: 40px;">97153 97154 97156 if BA is providing supervision to a Mentored BA 97157 if BA is providing supervision to a Mentored BA 97158 if BA is providing supervision to a Mentored BA</p> <p style="padding-left: 40px;">Q3014 as appropriate.</p> <p><u>In Conjunction with 97155:</u></p> <p style="padding-left: 40px;">Indirect T1026 UD Case Supervision and Clinical Management</p> <ul style="list-style-type: none"> • When the BA/Mentored BA is conducting an annual or medically warranted 97151, 97152, 0362T or a SCP is conducting 0362 to determine if |
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| | | <p>0373T is medically warranted, and the eligible recipient is receiving Stage 3 services, the BA/Mentored BA/Supervising BAA may continue 97155.</p> <p><u>Do Not Bill:</u> Direct T1026 UD Case Supervision 97155 if the BA/Mentored BA/Supervising BAA is directly rendering the service.</p> |
| <p>97156 <i>Replacing 03670T</i></p> | <p>BA Mentored BA Supervising BAA</p> | <p><u>ABA Stage 3 –Family Adaptive Behavior Treatment Guidance with or without the eligible recipient Present – One Family Set</u></p> <p>The BA/Mentored BA/Supervising BAA helps the members of the Family Set learn how to identify behavioral problems and how to implement treatment strategies to minimize the eligible recipient’s destructive behavioral concerns.</p> <p><u>Bill in 15-minute units.</u></p> <p>Maximum number of units per 97156 for entire Family Set: thirty-two 15-minute units or eight hours per day when medically warranted, see Adult Tiers Two and Three below.</p> <p><u>Prior Auth: NO</u> It is MAD’s intention to support a member of the eligible recipient’s Family Set to take advantage of any opportunity to enhance their engagement in the eligible recipient’s ABA Stage 3 services. Recipients may or may not be present for 97156. An eligible recipient’s Family Set may access 97156 after the eligible recipient’s Behavioral/Functional Analytic Assessment is scheduled and the assessment is being conducted.</p> <p>Any member of the Family Set is approved to participate in 97156 with or without the eligible recipient present. When an eligible recipient is not present during 97156, they may receive 97153, 97154 and 97158.</p> <p>A Family Set is inclusive of the eligible recipient's family members, caregivers or other support individuals. Bill for the entire Family Set as one 97156, do not bill each individual member of the Family Set separately. However, if the BA/Mentored BA/Supervising BAA meeting with a member of the Family on different days or times, bill 97156 separately.</p> <p><u>CMS Medicaid NCCI MUE limits:</u> 97156 to twenty-four 15-minute units or six hours per day.</p> <ol style="list-style-type: none"> For an adult recipient accessing Adult ABA Tier Two or Three services, they receive additional 97156 services as medically warranted up to thirty-two 15-minute units and documented in the eligible recipient’s clinical record. If the units exceed |

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| | | <p>twenty-four 15-minute units, bill no more than this amount per claim line.</p> <ol style="list-style-type: none"> For an adult recipient accessing Adult ABA Tier Two or Three, see Adult ABA Tier Two or Three for a detailed description of limits. <p><u>Telemedicine with the eligible recipient present:</u></p> <ol style="list-style-type: none"> When the eligible recipient is present with a member of the Family Set and the BA/Mentored BA/Supervising BAA is at a different location, the site the eligible recipient is located bills Q3014. The site the BA/Mentored BA/Supervising BAA is located does not bill Q3014 as their location is considered the distant site. When members of the Family Set are in different locations than where the eligible recipient is, the sites these Family Set members are located bill Q3014. If the eligible recipient is present with a member of the Family Set and the BA/Mentored BA/Supervising BAA is located at the same site, this site does not bill Q3014 as 97156 is rendered face to face with the eligible recipient. If a member of the Family Set is in the same location as the BA/Mentored BA/Supervising BAA, this site does not bill Q3014 as wherever the BA/Mentored BA/Supervising BAA is located is considered the distant site when the eligible recipient is in a different location. <p><u>Telemedicine without the eligible recipient Present:</u></p> <ol style="list-style-type: none"> When members of the Family Set and the BA/Mentored BA/Supervising BAA are at different locations, each site bills Q3014. The BA's/Mentored BA's/Supervising BAA's location does not bill Q3014 as their location is considered the distant site. If a member of the Family Set and the BA/Mentored BA/Supervising BAA are located at the same site, this site does not bill Q3014. <p>Prior to rendering 97156, the BA/Mentored BA/Supervising BAA may bill Indirect T1026 UD Case Supervision for the BA/Mentored BA/Supervising BAA and the BAA/BT to review how the members of the Family Set are implementing ABA Stage 3 services to develop individualized guidance when rendering 97156.</p> <p>After 97156, the BA/Mentored BA/Supervising BAA bills Indirect T1026 UD Clinical Management to analyze the interactions and concerns raised by the Family Set, and if needed, modify the eligible recipient's Treatment Protocols or ABA Stage 3 Treatment Plan to address these concerns brought up during the 97156 session with the Family Set. The BA/Mentored BA/Supervising BAA bills Indirect T1026 UD to discuss with the Mentored BA/BAA/BT.</p> |
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| | | <p>After 97156, the BA/Mentored BA/Supervising BAA may bill Indirect T1026 UD to analyze the graphed data collection and results, and if needed, modify the individual or group Treatment Protocols or ABA Stage 3 Treatment Plan. The BA/Mentored BA/Supervising BAA bills Indirect T1026 UD to discuss changes with the Mentored BA/BAA/BT.</p> <p><u>Concurrent Billing:</u> 97155</p> <ul style="list-style-type: none"> • A BAA/BT may render 97153 or 97154 and bill for these codes when the eligible recipient is not present with the Family Set and the BAA is not rendering 97156 as these are two distinct services. <p>Q3014 as appropriate.</p> <p><u>In Conjunction with 97156:</u> 97153 97154 97155 97157 97158</p> <p>Indirect T1026 UD Case Supervision and Clinical Management</p> <ul style="list-style-type: none"> • When the BA /Mentoring BA is conducting the annual or additional 97151, 97152, 0362T or a SCP is conducting 0362T to determine if 0373T is medically warranted, an eligible recipient may continue 97156. <p><u>Do Not Bill:</u> Direct T1026 UD Case Supervision as the primary focus is on the practitioner, not the eligible recipient. 97155 if the BA/Mentored BA/Supervising BAA is directly rendering the service</p> |
| <p>97157 <i>Replacing 0371T</i></p> | <p>Qualifying Psychologist BCBA-D BCBA Mentored BA</p> | <p><u>ABA Stage 3 – Multi-Family Group Adaptive Behavior Treatment Guidance – Without Recipients</u></p> <p><u>Bill in 15-minute units.</u></p> <p>The BA/Mentored BA helps the members of the multiple Family Sets learn how to identify behavioral problems and how to implement treatment strategies to minimize the eligible recipient’s destructive behavioral concerns.</p> <p><u>Prior Auth: NO</u> It is MAD’s intention to support a member of the eligible recipient’s Family Set to take advantage of any opportunity to enhance their engagement in the eligible recipient’s ABA Stage 3 services. No recipients are present for 97157. An eligible recipient’s Family Set may access 97157 after the eligible</p> |

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| | <p>recipient’s Behavioral/Functional Analytic Assessment is scheduled and when the assessment is being conducted.</p> <ul style="list-style-type: none"> • Any member of the Family Set is approved to participate in 97157 while the eligible recipient is receiving 97153, 97154 and 97158. • A member of the Family Set is approved to participate in any session of 97157 when approved by the eligible recipient’s BA/Mentored BA. <p><u>CMS Medicaid NCCI MUE limits:</u> 97157 up to sixteen 15-minute units or four hours per day.</p> <ol style="list-style-type: none"> 1. For an adult recipient accessing Adult ABA Tier Two or Three services, they receive additional 97157 services up to thirty-two 15-minute units as medically warranted and documented in the eligible recipient’s clinical record. If the units exceed sixteen 15-minute units, bill no more than this amount per claim line. 2. For an adult recipient accessing Adult ABA Tier One, Two or Three, see Adult ABA Tier Two or Three (above) for a detailed description of limits. <p><u>Telemedicine without the eligible recipient Present:</u></p> <ol style="list-style-type: none"> 1. When members of the different Family Sets and the BA/Mentored BA are at different locations, the site where these members are located bills Q3014. The BA/Mentored BA’s location does not bill Q3014 as their location is considered the distant site. 2. If a member of one of the Family Sets and the BA/Mentored BA are located at the same site, this site does not bill Q3014. <p>Prior to rendering 97157, the BA/Mentored BA may bill Indirect T1026 UD Case Supervision for the BA/Mentored BA and the Mentored BA/BAA/BT to review any changes based on the results of the BA’s/Mentored BA’s Indirect T1026 UD Clinical Management when there is a modification in recipient’s Treatment Protocol or ABA Stage 3 Treatment Plan.</p> <p>After 97157, the BA/Mentored BA may bill Indirect T1026 UD Clinical Management to analyze the interactions and concerns raised by the Family Set, and if needed, modify the eligible recipient’s Treatment Protocols or ABA Stage 3 Treatment Plan to address these concerns brought up during the 97157 session with the Family Set. The BA/Mentored BA bills Indirect T1026 UD Case Supervision to discuss with the Mentored BA/BAA/BT.</p> <p><u>Concurrent Billing:</u> 97155 Q3014</p> <p><u>In Conjunction with 97157:</u> 97153</p> |
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| | | <p>97154 97156 97158 Indirect T1026 UD Case Supervision and Clinical Management</p> <ul style="list-style-type: none"> When the BA/Mentored BA is conducting the annual or medially warranted 97151, 97152, 0362T or a SCP is conducting 0362T to determine if 0373T is medically warranted, recipient may continue 97157 as approved. A BAA/BT may render and bill 97153 or 97154 to an eligible recipient who is not present with the Family Set as these are two distinct services. <p><u>Do Not Bill:</u> Direct T1026 UD Case Supervision as the primary focus is on the practitioner, not the eligible recipient. 97155 if the BA/Mentored BA is directly rendering the service</p> |
| <p>97158</p> | <p>BA Mentored BA</p> | <p><u>ABA Stage 3 Treatment Protocol Modification – Recipient Group</u></p> <p>The BA/Mentored BA assists recipients to improve their social skills through practice, corrective feedback, and homework assignments, focusing on each recipient’s individual social and behavior issues. The BA/Mentored BA oversees and is responsive to each recipient’s needs and makes appropriate adjustments for the individual recipients and the group as necessary in real time. A group is constructed of two to six recipients and may include Medicaid and non-Medicaid recipients.</p> <p><u>Bill in 15-minute units.</u></p> <p><u>Prior Auth: NO</u></p> <p>97153, 97154 and 97158 - for an adult recipient accessing: Adult ABA Tier One services a limit of forty to sixty 15-minute units or 10 to 15 hours of COMBINED 97153, 97154, and 97158 units is allowed. Adult ABA Tier Two services a limit of 80 to 120 15-minute units or twenty to thirty hours of COMBINED 97153, 97154, 97158 units is allowed. Adult ABA Tier Three services a limit of 120 to 160 15-minute units or thirty to forty hours of COMBINED 97153, 97154, 97158 is allowed.</p> <p><u>CMS Medicaid NCCI MUE limits:</u></p> <ul style="list-style-type: none"> 97158 to sixteen 15-minute units or four hours per day. |

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| | | <ul style="list-style-type: none"> For an adult recipient accessing Adult ABA Tier Two or Three services, they receive additional 97158 services up to twenty-four 15-minute units as medically warranted and documented in the eligible recipient’s clinical record. If the units exceed sixteen 15-minute units, bill no more than this amount per claim line. <p><u>The differences between 97154 and 97158 are:</u></p> <ol style="list-style-type: none"> 97154 may be rendered by a BA/Mentored BA/BAA/BT and the focus is the eligible recipient’s treatment protocols delivered in a group setting and there is no modification to Treatment Protocols. 97158 is rendered only by a BA/Mentored BA. 97158 includes modification to an eligible recipient’s Treatment Protocols during the group session. <p>Prior to rendering 97158, the BA/Mentored BA may bill Indirect T1026 UD Case Supervision for the BA/Mentored BA and the Mentored BA/BAA/BT to review any changes based on the results of the BA’s/Mentored BA’s Indirect T1026 UD Clinical Management when there is a modification in recipient’s Treatment Protocol or ABA Stage 3 Treatment Plan.</p> <p>After 97158, the BA/Mentored BA may bill Indirect T1026 UD Clinical Management to analyze the interactions and concerns raised during the session, and if needed, modify the eligible recipient’s Treatment Protocols or ABA Stage 3 Treatment Plan to address these concerns brought up during the 97158 session. The BA/Mentored BA may bill Indirect T1026 UD Case Supervision to discuss with the Mentored BA/BAA/BT.</p> <p><u>Concurrent Billing:</u> 97155</p> <p><u>In Conjunction with 97158:</u> 97153 97154 97156 97157 Indirect T1026 UD Case Supervision and Clinical Management</p> <ul style="list-style-type: none"> When the BA/Mentored B is conducting the annual or medically warranted 97151, 97152, 0362T or a SCP is conducting 0362T to determine if 0373T is medically warranted, recipient may continue 97158 as approved. <p><u>Do Not Bill:</u> Direct T1026 UD Case Supervision 97155 if the BA/Mentored BA is directly rendering the service.</p> |
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STAGE 3 ABA SPECIALTY CARE

6.A Allowed Practitioner -Specialty Care Practitioner (SCP):

ABA Specialty Care services provide different areas of specialization of ABA Stage 3 services; for example, areas such as aggression and self-injury. Each ABA Specialty Care Area is conceptualized as a continuum of services. The continuum extends from least-to-most intensive, which is determined by the level of service required to support the eligible recipient. A more intensive level of service requires the SPC to have extensive education and training beyond their certification or licensing board requirements to practice. The SCP must be a BCBA, BCBA-D or a Qualifying Psychologist and must successfully complete a criminal background registry check; a qualifying psychologist must possess and maintain their license and a BCBA or BCBA-D must possess and maintain BACB certification. Regardless if the SCP applicant is currently enrolled as an ABA Stage 2 and 3 practitioner or another provider type, they must complete a SCP attestation. Attestations are attached to the Behavioral Health Policy and Billing Manual and on the HSD website Provider Tab under that tab ABA Attestations.

<https://www.hsd.state.nm.us/providers/provider-packets.aspx>

Option 1 Coursework and Experiential Training

ABA Specialty care practitioner graduate coursework and experiential training:

- a. The SCP applicant must hold documentation of graduate level coursework specific to the assessment and treatment of an ASD referral concern associated with an ABA Specialty Care Area. The graduate level coursework must be the equivalent of at least one 3-credit hour course i.e., 45 classroom contact hours and 45 non-classroom contact hours, specific to the ABA Specialty Care Area they intend to address with an eligible recipient. In other words, a SCP can only render ABA Specialty Care services for the ABA Specialty Care Area for which they have met the advanced training and experience requirements; and
- b. Complete 500 hours in the specific ABA Specialty Care Area under supervision from a BCBA, BCBA-D, a Qualifying Psychologist, or other credentialed practitioner who has 3 or more years of documented experience in the specific ABA Specialty Care Area. The 500 hours must be in a specific ABA Specialty Care Area implementing treatment protocols by either working directly with an eligible recipient or directing a BA/Mentored BA/Supervising BAA/RBT/BCAT working with an eligible recipient with at least 125 delivery hours acquired post master's degree. Not more than 350 delivery hours may be counted from meeting their BCBA, BCBA-D, or Qualifying Psychologist certification requirements, implementing the specific ABA Specialty Care treatment protocols with working directly with an eligible recipient or directing a BAA or BT working with an eligible recipient. The 500 hours must include 25 hours of directly supervised case management in the ABA Specialty Care Area.

Option 2 Experiential Training Only:

The SCP applicant must complete:

- a. 1,000 hours in the specific ABA Specialty Care Area under supervision by a BCBA, BCBA-D, Qualifying Psychologist, or other credentialed practitioner who has three or more years of documented experience in the ABA Specialty Care Area. A Mentored BA is not approved.
- b. The 1,000 hours must be in a specific ABA Specialty Care Area implementing treatment protocols by either working directly with an eligible recipient or directing a BA/Mentored BA/BAA/RBT/BCAT working with an eligible recipient with at least 250 delivery hours acquired post master's degree.
- c. Not more than 712.5 delivery hours may be counted from meeting their BCBA, BCBA/D or Qualifying Psychologist certification requirements, implementing the specific ABA Specialty Care

Area treatment protocols by working directly with an eligible recipient or directing a BA/Mentored BA/BAA/RBT/BCAT working with an eligible recipient.

- d. The 1,000 hours must include 37.5 hours of directly supervised case management in the ABA Specialty Care Area.

6.B Prior Authorization of ABA Specialty Care Services:

Prior Authorization request for ABA Specialty Care services are typically given to support moderate to severe cases. Justification of ABA Specialty Care services is determined by:

1. frequency, intensity, or chronicity of behavior;
2. potential for harm to self or others,
3. disruption of quality of life for the eligible recipient and for their Family Set; or
4. combinations of (a) through (c).

6.C Process:

1. The BA/Mentoring BA first determines the eligible recipient requires specialized services outside the scope of ABA Stage 3 services.
2. With the approval of the eligible recipient, recipient's appropriate member of the Family Set, the BA/Mentoring BA contacts an approved MAD SCP.
3. If after review of the eligible recipient's record the SCP determines ABA Specialty Care services may be medically warranted, the SPC conducts without Prior Authorization **0362T and 0373T**.
4. When the SCP determines the eligible recipient meets one or more of the ABA Specialty Care services, the SCP submits a Prior Authorization including the same information required in the ABA Stage 3 Prior Authorization request. In addition to this information, the SCP details whether ABA Stage 3 services are to continue, are modified or temporary suspended while ABA Specialty Care services are implemented.

6.D ABA Specialty Care Areas

The following areas have been identified as common Specialty Care Areas. This list should not be considered exhaustive. If an eligible recipient presents with concerns not included in the list below, contact the MAD ABA Manager for assistance.

1. **Aggression** - behaviors that place other individuals at risk of harm (e.g., hitting, kicking, biting). At times, other forms of behavior not considered aggression might place others at risk. For example, property destruction (e.g., throwing chairs, breaking windows) may impose a risk to others that warrants specialty care. Threats of aggression do not always warrant ABA Specialty Care services. Threats may warrant ABA Specialty Care services if the threat is deemed plausible. Threats of aggression might warrant coordination with other practitioners (e.g., psychiatrist) and/or utilization of other supports (e.g., inpatient hospitalization).
2. **Self-injury** - behaviors that place the eligible recipient at risk of harm (e.g., head banging, biting). The behaviors are not limited to harm resulting from self-injury. For example, elopement might create a substantial risk of harm (e.g., running into traffic).
3. **Sleep dysregulation** - the eligible recipient's hours of sleep are consistently much less than the recommended levels (e.g., National Sleep Foundation recommendations, American Academy of Pediatrics recommendations) and/or disruption of a member of the Family Set who resides with the eligible recipient sleep patterns (e.g., missing work due to sleep deprivation) result from unusual sleep patterns of the eligible recipient.
4. **Feeding disorders** - the eligible recipient is at high-risk for health issues associated with eating (e.g., short gut, breathing problems), severe lack of eating (e.g., less than 20% of nutritional needs

by mouth), high levels of inappropriate behavior during meals, and ingestion of non-edible items (i.e., pica). Food selectivity, increasing variety, advancing textures do not typically warrant ABA Feeding Specialty Care, unless there are further complications as listed above.

| 6.E Billing Instructions for ABA Specialty Care | | |
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| 0373T | Specialty Care Practitioner (SCP) | <p><u>ABA Stage 3 Specialty Care - Adaptive Behavior Treatment with Protocol Modification</u></p> <p>The SCP directing two or more BAs/Mentored BAs/BAAAs/RBTs/BCATs (practitioners) who provoke responses from various but specific environmental circumstances in response to which the eligible recipient may experience or has experienced dangerous or destructive behaviors. The SCP studies the eligible recipient’s responses and makes modifications until the ABA Specialty Care Area Treatment Protocol goals have been met. 0373T allows the practitioner to serve as a proxy by capturing the data the SCP has directed of them.</p> <p><u>Bill in 15-minute units.</u></p> <p><u>Prior Authorization: Yes</u> The SCP must submit the Specialty Care Treatment Protocols, and all other documentation required by the MCO or TPA.</p> <p><u>CMS Medicaid NCCI MUE limits:</u> 0373T to twenty 15-minute units or five hours</p> <p><u>0373T Requirements:</u></p> <ol style="list-style-type: none"> 1. SCP must be onsite (not at the eligible recipient’s home) with the eligible recipient, meaning immediately available and interruptible; and 2. Two or more practitioners are present with recipient; and 3. SCP completes and bills 0362T for the functional assessment and bills 0373T for the report/treatment plan/protocols. 4. Recipient must be exhibiting one or more of the Specialty Care Areas; and 5. The SCP must complete a Risk Assessment billing 0373T to determine if the practitioner or the eligible recipient will wear protective equipment for the safety of each and then design the eligible recipient’s customized environment where they are located based on the eligible recipient’s behavior for 0362T and 0373T. <p>0373T cannot be rendered in the eligible recipient’s home. It must be rendered in the SCP’s clinic or center after a Risk Assessment (not Targeted/Risk Evaluation (T1026 HK)) is completed in order to customize the environment based on the eligible recipient’s serious dangerous or destructive behavior. Bill 0373T</p> |

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| | | <p>for the Risk Assessment and any customization of the environment and any materials necessary to render 0362T or 0373T.</p> <p>The SCP bills 0373T to:</p> <ul style="list-style-type: none"> • Conduct a Risk Assessment. • Customize the environment and materials the eligible recipient will be assessed in and where 0362 and 0373T will be delivered for each session. • Provide specialized instructions unique to the eligible recipient to the practitioners will be assisting the SCP render 0373T. • Score and analyze results of 0362T. • Interview Family Set members and other providers engaged with recipient, and if applicable, the eligible recipient. • Design and oversee 0373T Treatment Protocols implementation. • Renders 0373T Treatment Protocols directly with two or more practitioners present. • If approved by the SCP, a BA/Mentored BA/BAA/RBT/BCAT bills for these services under the SCP's 1st Modifier. <p>As 0373T requires at least two practitioners in addition to the SCP, only one practitioner bills 0373T using the SCP's first modifier at any time regardless of the number of practitioners present.</p> <p>If the practitioner does not have the expertise to render 0373T, the SCP bills 0373T to provide specific training to the eligible recipient that are not included in their BACB or BICC certification requirements and are unique to the eligible recipient. 0373T cannot include time spent instructing a practitioner on skills or training related to their BACB or BICC certification. MAD considers these non-reimbursable supervision requirements necessarily to the practitioner gaining and retaining BACB or BICC certification.</p> <p>For clinical management and case supervision and other activities traditionally billed under Direct and Indirect T1026 UD, for Specialty Care Services bill those activities under 0373T.</p> <p><u>Concurrent Billing:</u> When the SCP directly renders some of the Specialty Care Treatment Protocols, the SCP bills 0373T in addition to the other practitioner billing 0373T. In this situation, bill the other practitioner's time on one claim line utilizing the SCP's 1st Modifier, and the SCP's time on separate claim line.</p> <p><u>In Conjunction with 0373T:</u> 0362T</p> <ul style="list-style-type: none"> • Q3014 when indirect 0373T is rendered, such as interviews with Family Set • If the SCP agrees, 97153, 97154, 97155, 97156, 97157, 97158 may be billed by the approved |
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| | | <p>practitioners for these services. SCP approval to continue approved Stage 3 services must be documented in the eligible recipient’s clinical file.</p> <p><u>Do Not Bill:</u> 97151 97152 T1026 Indirect and Direct UD</p> |
|--|--|---|

[http://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20310/8_310_2%20Revised\(1\).pdf](http://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20310/8_310_2%20Revised(1).pdf)

http://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20308/8_308_9.pdf

ABA STAGE 1-3 NON-COVERED SERVICES

MAD does not reimburse for the following when rendering ABA Stage 1 through 3 and Specialty care services:

1. Activities that are not designed to accomplish the objectives delineated in covered services and that are not included in the ABA Treatment Plan or Specialty Care Treatment Plan;
2. Activities that are not based on the principles and application of applied behavior analysis;
3. Activities that are not empirically supported (i.e., activities that are not supported by a substantive body of peer-reviewed, published research);
4. Activities that take place during school hours and/or have the potential to supplant educational services; however, MAD is allowing ABA services during school time which support the recipient participate in their educational services;
5. Activities that are better described as another therapeutic service (e.g., speech language therapy, occupational therapy, physical therapy, counseling, etc.), even if the provider has expertise in the provision of ABA; and
6. Activities that are characterized as staff training or certification/licensure requirements, rather than Indirect T1026 UD Clinical Management or Case Supervision.

These links are current. Recommended to review for the most recent publications.

Links

All MAD attestation templates for ABA providers and Specialty Care Providers are located at: <http://www.hsd.state.nm.us/providers/provider-packets.aspx> .

Qualifying Psychologist

<https://www.bacb.com/supervision-and-training/> <https://www.bacb.com/bcba/#BCBAD>

This is not a link to required certification. It is questionable if this is actually approved by the BACB

Task Lists

RBT Task List <https://www.bacb.com/wp-content/uploads/2017/09/161019-RBT-task-list-english.pdf>

BCAT Task List <https://www.behavioralcertification.org/Content/Downloads/TASKLIST-BICC-2015.pdf>

BCBA and BCaBA <https://www.bacb.com/wp-content/uploads/2017/09/160101-BCBA-BCaBA-task-list-fourth-edition-english.pdf>

Handbooks

BCAT

https://www.behavioralcertification.org/Content/Downloads/BCAT_CANDIDATE_HANDBOOK.pdf

This is not a current document.

Standards for Supervision

BCaBA

<https://www.bacb.com/wp-content/uploads/161216-standards-for-supervision-of-BCaBAs.pdf>

[Doesn't open](#)

RBT

<https://www.bacb.com/rbt/responsible-certificants/>

BCAT

<https://behavioralcertification.org/providers/>

NMAC RULES OF INTEREST:

General Provider Policies

https://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20302/8_302_1.pdf

Billing for Medicaid Services

https://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20302/8_302_2%20Rule.pdf

General Benefit Descriptions

[https://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20310/8_310_2%20Revised\(1\).pdf](https://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20310/8_310_2%20Revised(1).pdf)

Developmental Disabilities Home and Community-Based Services Waiver

[https://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20314/8_314_5\(1\).pdf](https://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20314/8_314_5(1).pdf)

Mi Via Home and Community-Based Services

Waiver https://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20314/8_314_6.pdf

Specialized Behavioral Health Provider Enrollment and Reimbursement

https://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20314/8_314_6.pdf

Claim Hearings

https://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20352/8_352_2%20NMAC%20with%20index%2006172014.pdf

Provider Hearings

https://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20352/8_352_3.pdf

MCO SPECIFIC NMAC RULES:

Benefit Package

https://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20308/8_308_9%20Rule.pdf

Community Benefit

https://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20308/8_308_12%20Rule.pdf

Grievances and Appeals (for MCO members and providers)

https://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20308/8_308_15.pdf

MAD SUPPLEMENTS – Please check this link prior to rendering services. There are supplements specific to how services are rendered during the New Mexico Public Health Emergency. Ongoing supplements can be found following link that impact how MAD directs services be rendered.

https://www.hsd.state.nm.us/providers/Registers_and_Supplements.aspx

FOR RECIPIENTS ON THE ALTERNATIVE BENEFIT PROGRAM (ABP)

MAD Administered Benefits and Limitation of Services

https://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20309/8_309_4%20Update.pdf

