

Clinical Policy: Applied Behavioral Analysis Documentation Requirements

Reference Number: CP.BH.105
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Description

Applied Behavior Analysis (ABA) services must meet specific documentation requirements and adhere to applicable regulations, accreditation standards, and professional practice standards. Appropriate and accurate documentation is critical to providing member/enrollees with quality care, treatment planning and progress monitoring. It helps facilitate communication with all team members participating in the plan of care, ensuring appropriate utilization reviews and regulatory reimbursement compliance.¹

Policy/Criteria

- I. It is the policy of Centene Advanced Behavioral Health and health plans affiliated with Centene Corporation® that, when a covered benefit, requests for Applied Behavioral Analysis (ABA) services contain all the following requirements:
 - A. Diagnosis meets one of the following:
 1. Confirmed autism spectrum disorder (ASD) diagnosis according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5 TR) criteria if not specified by applicable state-defined ABA criteria;
 2. An appropriate diagnosis as specified by applicable state-defined ABA criteria;
 - B. Recommendation for ABA services by a qualified licensed health care provider working within their scope of practice, as specified by applicable state-defined ABA criteria;
 - C. A comprehensive diagnostic evaluation; Note: should be consistent with state-defined ABA criteria, if applicable;
 - D. Service type documentation meets one of the following:
 1. *Behavior assessment* report, completed prior to requesting treatment services, includes all the following:
 - a. Record review;
 - b. Clinical interview;
 - c. Risk/safety assessment (as applicable);
 - d. At least one of the following:
 - i. Functional analysis assessment;
 - ii. Skills-based assessment;
 - iii. Standardized assessment;
 - e. Assessments from other professionals (as applicable);
 - f. Scoring or analysis of standardized testing (norm referenced and/or criterion referenced);
 - g. Treatment setting and environmental analysis;
 - h. Direct observation and measurement of behavior (continuous and discontinuous);
 - i. Priority target behaviors, all the following:
 - i. Identification of priority behavior(s);
 - ii. Operational definition;

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- iii. Baseline data;
- iv. Proposed goals and objectives;
- 2. *Initial* treatment records include a treatment plan that aligns with the behavior assessment and includes all the following:
 - a. Assessments and procedure results;
 - b. Individualized goals and objectives with measurable target outcomes and timelines, considering all the following:
 - i. Member/enrollee's age;
 - ii. Current level (baseline);
 - iii. Treatment setting;
 - iv. Operational definition of target behavior and skill;
 - v. Interventions focused on active core symptoms and specific plan for generalization;
 - vi. Date of introduction;
 - vii. Estimated date of mastery;
 - c. Number of hours or units requested includes all of the following:
 - i. Direct service to the member/enrollee includes one of the following:
 - a) Focused ABA, up to 10 to 25 hours;
 - b) Comprehensive ABA, up to 30 to 40 hours;
 - c) Parent/caregiver training;
 - d) Case supervision;
 - e) Assessment;
 - d. Clearly identifies the schedule of services planned and the individuals responsible for delivering the services;
 - e. Coordination of care includes both of the following:
 - i. Identifies each alternative provider who is responsible for delivering services (as applicable);
 - ii. Dates and outcomes from coordination of care efforts;
 - f. Crisis plan;
 - g. Transition/Titration/Discharge plan includes all the following:
 - i. Specific titration goals and plan indicating how service hours will be titrated;
 - ii. Individualized, realistic and specific goals for discharge;
 - iii. Updated progress towards goals achieved over the authorization period;
 - iv. Recommended services member/enrollee can access upon discharge;
 - h. Signature, credential, and role of each person who reviewed and signed the plan;
 - 3. *Continuation* treatment records include all the following:
 - a. An updated behavior assessment and treatment plan, completed every six months (or less, as clinically appropriate, or as state mandated), describing all of the following:
 - i. Changes in treatment goals and interventions to include all the following:
 - a) Data and graph representation of mastery of skills noted in the treatment plan;
 - b) Changes in scores on standardized assessments over time;
 - c) Changes from the initial treatment plan;
 - d) Outcome measures of treatment goals;
 - ii. Transition plan which includes monitoring and evaluation details;

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- iii. Collaboration and coordination in care with other providers;
 - E. Service activity notes are completed prior to claim submission for all services rendered and include both of the following:
 - 1. Services provided by and documenting one of the following:
 - a. A registered technician's note identifies all the following:
 - i. Primary target areas addressed;
 - ii. Summary of techniques used during the session;
 - iii. Barriers to treatment plan implementation;
 - b. A qualified healthcare professional's note identifies all the following:
 - i. Primary target areas addressed or observed during session;
 - ii. List of protocol modifications made, if applicable;
 - iii. Direction of technician(s), if applicable;
 - iv. Direct treatment with member/enrollee if applicable;
 - v. Consultation or training with guardian(s)/caregiver(s), if applicable;
 - vi. Other activities as needed;
 - 2. All notes include all the following identification information:
 - a. Name of provider organization, clearly visible at the top of each note;
 - b. Member/Enrollee's name, listed on each page. Note: If the legal name differs from the preferred name, the legal name is noted at the top of the note. The preferred name should be noted in parentheses and used in the rest of the documentation;
 - c. Date of birth (DOB) or unique identifier (UI);
 - d. Date of rendered service;
 - e. Date of note creation (if different from the date of rendered service);
 - f. Time service was initiated and the time the service ended;
 - g. Pauses in services (indicating the time the service was paused and the time it resumed);
 - h. Location of services;
 - i. Type/Code of service provided;
 - j. Rendering clinician/technician's name, credentials, and dated signature;
 - k. Identification of all individuals actively participating during the session to include the relationship to the member/enrollee. Note: PHI or PII data for non-member/enrollee should not be included;
 - l. Summary of session activity;
 - m. Addendum (if applicable) includes both of the following:
 - i. Clear reference to the clinical note it is intended to supplement;
 - ii. Date completed.
- II.** It is the policy of Centene Advanced Behavioral Health and health plans affiliated with Centene Corporation that, when a member/enrollee no longer meets medical necessity criteria, a discharge summary is submitted which includes all the following, (as applicable):
- A. Referrals provided;
 - B. Progress summary (to include data and graphs as applicable);
 - C. Rationale/reason for discharge;
 - D. Date of discharge.

Background

According to the Council of Autism Service Providers (CASP)³, the following are considered the *core characteristics* of Applied Behavioral Analysis (ABA) and should be apparent throughout all phases of assessment and treatment:

1. Objective assessment and analysis of the person's condition by observing how the environment affects their behavior, as evidenced through appropriate measurement.
2. Understanding the context of the behavior and the behavior's value to the person, their caregivers, their family, and the community.
3. Promotion of the person's dignity.
4. Utilization of the principles and procedures of behavior analysis to improve the person's health, skills, independence, quality of life, and autonomy.
5. Consistent, ongoing, objective data analysis to inform clinical decision making.

The following are *essential practice elements* of ABA³:

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

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Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2023, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Providers should reference the most recent version of ABA Coding Coalition for information on Medically Unlikely Edits (MUEs), and related processes for code usage and descriptors. The Centers for Medicare & Medicaid Services guidelines should be used to determine the maximum units of service a provider can report under most circumstances during a single date of service.⁵

CPT®* Codes	Description
97151	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/ interpreting the assessment, and preparing the report/treatment plan
97152	Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes
0362T	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by

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CPT®* Codes	Description
	the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior
0373T	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed	11/23	11/23
Annual review. Policy restructured and reformatted to remove redundant information and clarity in documentation requirements throughout. Added inclusive language to allow for a variation of state allowances throughout the policy. Removed comprehensive assessment report criteria and replaced it with I.C. “Comprehensive diagnostic evaluation, consistent with state defined ABA criteria. Defined service documentation requirements, which are note listed as I.D.1., Behavior assessment, I.D.2., Initial treatment record requirements and I.D. 3. Continuation treatment records. Summarized treatment plan criteria and listed under the initial treatment records in I. D.2. Service activity note requirements are listed under I.E. Added Policy statement II to document discharge summary requirements if member/enrollee no longer meets medical necessity criteria. Background section reviewed and updated. References reviewed and updated. In the important reminder section, changed “ medical necessity” to “documentation” in the statement “The purpose of this clinical policy is to provide a guide...” because this is not a medical necessity policy.	12/24	12/24

References

1. Behavioral Health Center of Excellence – 101 Standard for the Documentation of Clinical Records for Applied Behavior Analysis Services. <https://www.bhcoe.org/standard/bhcoe-standard-101-standard-for-the-documentation-of-clinical-records-for-applied-behavior-analysis-services/>. Published January 1, 2021. Accessed November 22, 2024.
2. Behavioral Health Center of Excellence – 201 Standard for the Documentation of Clinical Records for Applied Behavior Analysis Services. <https://www.bhcoe.org/standards/>. July 1, 2022. Accessed November 22, 2024.
3. The Council of Autism Service Providers (CASP) Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers, 3rd Edition. <https://www.casproviders.org/standards-and-guidelines#practiceguidelines>. Updated April 29, 2024. Accessed November 22, 2024.

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4. The Council of Autism Service Providers (CASP) Practice Parameters for Telehealth-Implementation of Applied Behavior Analysis, 2nd Edition. https://assets-002.noviams.com/novi-file-uploads/casp/pdfs-and-documents/Final-Copy-Practice-Parameters-Telehealth-ABA-AMA-References-12_2_2199.pdf. Updated December 1, 2021. Accessed November 22, 2024.
5. ABA Coding Coalition Model Coverage Policy for Adaptive Behavior Services. <https://abacodes.org/wp-content/uploads/2022/01/Model-Coverage-Policy-for-ABA-01.25.2022.pdf>. Updated January 2022. Accessed November 22, 2024.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide documentation, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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