


Washington Apple Health (Medicaid)

Applied Behavioral Analysis (ABA) Program Billing Guide

(For clients age 20 and younger)

October 1, 2017

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



About this guide*

This publication takes effect October 1, 2017, and supersedes earlier guides to this program.

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

What has changed?

Subject	Change	Reason for Change
Fully Integrated Managed Care (FIMC)	<p>Effective January 1, 2018, the agency is implementing a second FIMC region, the North Central (NC) region, which includes Douglas, Chelan, and Grant Counties.</p> <p>The agency has updated and consolidated the FIMC information in this guide and provided several hyperlinks to the agency's Managed Care webpage, the agency's Integrated physical and behavioral health care webpage, and the agency's Regional resource webpage.</p>	Notification of new region moving to fully integrated managed care (FIMC)

* This publication is a billing instruction.

How can I get agency provider documents?

To access provider alerts, go to the agency's [provider alerts](#) webpage.

To access provider documents, go to the agency's [provider billing guides and fee schedules](#) webpage.

Where can I download agency forms?

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

The screenshot shows the Washington State Health Care Authority website. The top navigation bar includes 'Search', 'Home', 'About HCA', and 'Contact HCA'. Below this is a dark blue header with 'Billers and providers' and a 'ProviderOne' button. A secondary navigation bar contains 'Forms & publications', 'News', 'Electronic Health Records (EHR)', and 'Contact Us'. The main content area is titled 'Forms & publications' and features a search interface with a search box, a 'Search' button, and dropdown menus for filters and sorting options.

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Resources Available

Topic	Resource
Prior Authorization (PA) or Limitation Extension (LE)	<p>For all requests for PA or LE, the following documentation is required:</p> <ul style="list-style-type: none"> • A completed, TYPED, General Information for Authorization form, HCA 13-835. This request form MUST be the initial page when you submit your request • A completed Applied Behavior Analysis Services request form, HCA 12-411, for initial PA requests and recertification. • A completed Assessment and Behavior Change Plan form, HCA 13-400, for PA requests and recertification. <p>For information about downloading agency forms, see Where can I download agency forms?</p>
Becoming a provider or submitting a change of address or ownership	<p>See the agency's ProviderOne Resources webpage</p>
Contacting Provider Enrollment	
Finding out about payments, denials, claims processing, or agency managed care organizations	
Electronic billing	
Finding agency documents (e.g., billing guides, fee schedules)	
Private insurance or third-party liability, other than agency-contracted managed care	
Access E-learning tools	<p>See the agency's ProviderOne Resources webpage</p>
More information	<p>See the agency's Autism and Applied Behavior Analysis (ABA) therapy webpage</p>

Definitions

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

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

Examples of autism diagnostic tools include:

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

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

Examples of screening tools include:

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

Behavioral Health Organization (BHO) - A single- or multiple-county authority or other entity operating as a prepaid health plan with which the agency or the agency's designee contracts for the delivery of

community outpatient and inpatient mental health and substance use disorder services in a defined geographic area. (WAC [182-500-0015](#))

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

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

Division of Behavioral Health and Recovery (DBHR) – The division within the Washington State Department of Social and Health Services that assesses and treats clients with co-occurring mental health and substance use disorders.

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

National Provider Identifier (NPI) – See WAC [182-500-0075](#).

Program Overview

Who should read this guide?

This guide contains instructions for Centers of Excellence (COEs) who conduct the clinical diagnostic evaluation and applied behavior analysis (ABA) service for providers. This guide may also be helpful to primary care providers who want to assist children and their families in accessing ABA services and navigating the pathway to care.

What is ABA?

ABA is an empirically validated approach to improve behavior and skills related to core impairments associated with autism and a number of other developmental disabilities. ABA involves the systematic application of scientifically validated principles of human behavior to change inappropriate behaviors. ABA uses scientific methods to reliably demonstrate that behavioral improvements are caused by the prescribed interventions. ABA is presently considered the gold standard of autism interventions.

ABA's focus on social significance promotes a family-centered and whole-life approach to intervention. Common methods used include: assessment of behavior, caregiver interviews, direct observation, and collection of data on targeted behaviors.

A single-case design is used to demonstrate the relationship between the environment and behavior as a means to implement client-specific ABA therapy treatment plans with specific goals and promote lasting change. ABA also includes the implementation of a functional behavior assessment to identify environmental variables that maintain challenging behaviors and allow for more effective interventions to be developed that reduce challenging behaviors and teach appropriate replacement behaviors.

What is the purpose of the ABA program?

WAC [182-531A-0100](#)

ABA helps children age 20 and younger, and their families improve the core symptoms associated with autism spectrum disorders or other developmental disabilities. ABA services support learning and assist with the development of social, behavioral, adaptive, motor, vocational, and cognitive skills.

Client Eligibility

WAC [182-531A-0400](#)

Who is eligible?

To be eligible for applied behavior analysis (ABA) services, a client must meet all of the following:

- Be age twenty or younger (the day treatment program is restricted to age two through five)
- Be covered under Washington Apple Health
- Have a physician's order stating that the client is likely to benefit from participation

AND one of the following:

- Have a diagnosis of an autism spectrum disorder, as defined by the most current version of the *Diagnostic and Statistical Manual*
- Have a developmental disability for which there is evidence ABA services are effective

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

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

Clients who are receiving mental health services through a behavioral health organization (BHO) are also eligible for ABA services.

Effective July 1, 2017, not all Apple Health clients were enrolled in a BHO/FIMC/BHSO

On July 1, 2017, some Apple Health clients were not enrolled in a behavioral health organization (BHO), fully integrated managed care (FIMC), or behavioral health services only (BHSO) program. For these clients, substance use disorder (SUD) services are covered under the fee-for-service (FFS) program.

Effective January 1, 2017, some fee-for-service clients who have other primary health insurance were enrolled into managed care

On January 1, 2017, the agency enrolled some fee-for-service Apple Health clients who have other primary health insurance into an agency-contracted managed care organization (MCO).

This change did not affect all fee-for-service Apple Health clients who have other primary health insurance. The agency continues to cover some clients under the fee-for-service Apple Health program, such as dual-eligible clients whose primary insurance is Medicare.

For additional information, see the agency's [Managed Care webpage](#), under Providers and Billers.

Effective April 1, 2016, important changes to Apple Health

These changes are important to all providers because they may affect who will pay for services.

Providers serving any Apple Health client should always check eligibility and confirm plan enrollment by asking to see the client's Services Card and/or using the ProviderOne Managed Care Benefit Information Inquiry functionality (HIPAA transaction 270). The response (HIPAA transaction 271) will provide the current managed care organization (MCO), fee-for-service, and Behavioral Health Organization (BHO) information. See the agency's [Regional Resources webpage](#).

New MCO enrollment policy – earlier enrollment

Beginning April 1, 2016, Washington Apple Health (Medicaid) implemented a new managed care enrollment policy placing clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This policy eliminates a person being placed temporarily in fee-for-service while they are waiting to be enrolled in an MCO or reconnected with a prior MCO.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health Managed Care.

Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Clients currently in fee-for-service or currently enrolled in an MCO are not affected by this change. Clients in fee-for-service who have a change in the program they are eligible for may be enrolled into Apple Health Managed Care depending on the program. In those cases, this enrollment policy will apply.

How does this policy affect providers?

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's [Get Help Enrolling](#) page.
- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's new policies.

Behavioral Health Organization (BHO)

The Department of Social and Health Services (DSHS) manages the contracts for behavioral health (mental health and substance use disorder (SUD)) services for nine of the Regional Service Areas (RSA) in the state, excluding Clark and Skamania counties in the Southwest Washington (SW WA) Region. BHOs replaced the Regional Support Networks (RSNs). Inpatient mental health services continue to be provided as described in the inpatient section of the [Mental Health Services Billing Guide](#). BHOs use the [Access to Care Standards \(ACS\)](#) for mental health conditions and [American Society of Addiction Medicine \(ASAM\)](#) criteria for SUD conditions to determine client's appropriateness for this level of care.

Fully Integrated Managed Care (FIMC)

For clients who live in a fully integrated managed care (FIMC) region, all physical health services, mental health services, and drug and alcohol treatment are covered and coordinated by the client's agency-contracted managed care organization (MCO). The Behavioral Health Organization (BHO) will not provide behavioral health services in these counties.

Clients living in an FIMC region will enroll with an MCO of their choice that is available in that region. If the client does not choose an MCO, the client will be automatically enrolled into one of the available MCOs, unless the client is American Indian/Alaska Native (AI/AN). Clients currently enrolled in one of the available MCOs in their region may keep their enrollment when the behavioral health services are added.

Effective July 1, 2017, American Indian/Alaska Native (AI/AN) clients living in an FIMC region of Washington must choose to enroll in one of the agency-contracted MCOs available in that region; or they may choose to receive all these services through Apple Health fee-for-service (FFS). If they do not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavior health services. For more information about the services available under the FFS program, see the agency's [Mental Health Services Billing Guide](#) and the [Substance Use Disorder Billing Guide](#).

For full details on FIMC, including which clients residing in an FIMC region are not enrolled with an MCO and information on complex behavioral health services for foster children in an FIMC region, see the agency's [Managed Care webpage](#), the agency's [Integrated physical and behavioral health care webpage](#), and the agency's [Regional resource webpage](#).

FIMC Regions

North Central Region (NC) – Douglas, Chelan and Grant Counties

Effective January 1, 2018, the agency will implement the second FIMC region known as the NC region which includes Douglas, Chelan, and Grant Counties. Clients eligible for managed care enrollment will choose to enroll in an available MCO in their region. Specific details, including information about mental health crisis services can be found on the agency's [Managed Care webpage](#), the agency's [Integrated physical and behavioral health care webpage](#), and the agency's [Regional resource webpage](#).

Southwest Washington Region (SW WA) – Clark and Skamania Counties

Effective April 1, 2016, the agency implemented the first FIMC region known as the SW WA region which includes Clark and Skamania Counties. Clients eligible for managed care enrollment choose to enroll in one of two available MCOs in this region: Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW).

Apple Health Core Connections (AHCC)

Coordinated Care of Washington (CCW) will provide all physical health care (medical) benefits, lower-intensity outpatient mental health benefits, and care coordination for all Washington State foster care enrollees. These clients include:

- Children and youth under the age of 21 who are in foster care
- Children and youth under the age of 21 who are receiving adoption support
- Young adults age 18 to 26 years old who age out of foster care on or after their 18th birthday

American Indian/Alaska Native (AI/AN) children will not be auto-enrolled, but may opt into CCW. All other eligible clients will be automatically enrolled.

AHCC complex mental health and substance use disorder services

AHCC clients who live in Skamania or Clark County receive complex behavioral health benefits through the Behavioral Health Services Only (BHSO) program in the SW WA region. These clients will choose between CHPW or MHW for behavioral health services, or they will be auto-enrolled into one of the two plans. CHPW and MHW will use the BHO Access to Care Standards to support determining appropriate level of care, and whether the services should be provided by the BHSO program or CCW.


Contact Information for Southwest Washington

Beginning on April 1, 2016, there is not a BHO in Clark and Skamania counties. Providers and clients must call the agency-contracted MCO for questions, or call Beacon Health Options for questions related to an individual who is not eligible for or enrolled in Medicaid.

If a provider does not know which MCO a client is enrolled in, this information can be located by looking up the patient assignment in ProviderOne.

To contact Molina, Community Health Plan of Washington, or Beacon Health Options, please call:

 MOLINA[®] HEALTHCARE	Molina Healthcare of Washington, Inc. 1-800-869-7165
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 COMMUNITY HEALTH PLAN of Washington	Community Health Plan of Washington 1-866-418-1009
---	---

Beacon Health Options	Beacon Health Options 1-855-228-6502
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How can I verify a client's eligibility?

Providers must verify that a client has Washington Apple Health coverage for the date of service, and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Verifying eligibility is a two-step process:

Step 1. Verify the client's eligibility for Washington Apple Health. For detailed instructions on verifying a client's eligibility for Washington Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's current [ProviderOne Billing and Resource Guide](#).

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

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

Note: Clients who wish to apply for Washington Apple Health may do so in one of the following ways:

1. By visiting the Washington Healthplanfinder's webpage at: www.wahealthplanfinder.org
2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)
3. By mailing the application to:
Washington Healthplanfinder
PO Box 946
Olympia, WA 98507

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

Provider Eligibility

WAC [182-531A-0800](#)

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

Two types of providers deliver services under the ABA program:

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

What is a Center of Excellence (COE)?

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

What are the qualifications for a COE?

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

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

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

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

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

Or

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

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

- ARNPs, physicians, and psychologists must have demonstrated expertise in diagnosing an autism spectrum disorder by doing one of the following:
 - ✓ Using a validated diagnostic tool.
 - ✓ Confirming the diagnosis by observing the client's behavior and interviewing family members.
 - ✓ Reviewing the documentation available from the client's primary care provider, individualized education plan, or individualized family service plan.
- ARNPs, physicians, and psychologists must understand the medically necessary use of ABA services.
- ARNPs, physicians, and psychologists must be sufficiently qualified to conduct and document a comprehensive diagnostic evaluation, and develop a multidisciplinary clinical treatment plan under WAC [182-531A-0500\(2\)](#).

Examples of providers who can qualify as a COE include:

- Multidisciplinary clinics.
- Individual qualified provider offices.
- Neurodevelopmental centers.

How to become recognized as a COE?

To apply to become a COE, contact the ABA program manager at ABA@hca.wa.gov.

Training is offered in various locations for physicians, ARNPs and interested community members based on interest and trainer availability. Contact the ABA program manager at ABA@hca.wa.gov.

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

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

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

Who can apply to provide ABA services?

Effective July 1, 2017, health care professionals with the following new credentials offered through the Department of Health are eligible to provide Apple Health-funded ABA services:

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

See [the DOH ABA credential webpage](#) for qualifications and application process.

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

WAC [182-531A-0800](#)

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

- DOH licensed behavior analyst (LBA); or
- DOH licensed assistant behavior analyst (LABA) with supervision from a LBA as defined by the BACB standards.

Additional requirements for LBAT enrollment

LBATs must meet both of the following:

- Have a signed CPA with the agency
- Be authorized to supervise ancillary providers

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

WAC [182-531A-0800](#)

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

- Free of license restrictions;
- In good standing with DOH;

AND one of the following:

- Certified by DOH as a CBT; or
- A DOH licensed mental health counselor, independent clinical social worker, or psychologist with a signed attestation regarding ABA qualifications on file with provider enrollment.

Additional requirements for CBT enrollment

All CBTs must have a signed CPA with the agency.

Becoming licensed as a facility-based day treatment program

WAC [182-531A-0600\(3\)\(a\)](#)

To apply to become an agency-approved day treatment program, complete and submit the *ABA Day Program Capacity Attestation* form, HCA 13-401. (See [Where can I download agency forms?](#)) This form is required to evaluate whether applicants meet program guidelines. This form must be completed by a provider in collaboration with the agency upon the initiation and any expansion of day treatment capacity.

Accessing ABA Services

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

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

Stage one: Referral to a Center of Excellence (COE) for an evaluation

Stage two: If ABA services are ordered, selection and receipt of an assessment from an ABA provider

Stage three: Delivery of ABA therapy services

Stage one of the pathway to care

WAC [182-531A-0500](#)

Referral

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

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

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

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

What does the COE do?

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

Required documentation

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

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

The comprehensive diagnostic evaluation

WAC [182-531A-0500](#) (2) and (3)

The comprehensive diagnostic evaluation must include:

- Results of routine developmental screening performed by the child's primary care provider at well child visits, if available.
- Audiology and vision assessment results, if available, or documentation that vision and hearing were determined to be within normal limits during assessment and not a barrier to completing a valid evaluation.
- The name of the completed autism screening questionnaire, including date completed and significant results, if available.
- Documentation of how the diagnosis was made or confirmed by a COE physician or psychologist that includes one of the following:
 - ✓ Results of formal diagnostic procedures performed by a clinician, including name of measure, dates, and results, as available
 - ✓ Clinical findings and observations used to confirm the diagnosis. The child's health care record may incorporate family member observations establishing the presence of any of the core symptoms of an autism spectrum disorder: Functional

impairment; delay in communication, behavior, or social interaction; or repetitive or stereotyped behavior.

- If available, documentation of a formal cognitive or developmental assessment performed by the COE or another qualified clinician that includes the name of the measure, dates, results, and standardized scores providing verbal, nonverbal, and full-scale scores. This may include school or early childhood education records. Examples of these assessment tools include the current version of the:
 - ✓ Mullen Scales of Early Learning
 - ✓ Wechsler Individual Achievement Test
 - ✓ Bayley Scales of Infant and Toddler Development
- If available, documentation of a formal adaptive behavior assessment performed by the COE or another qualified clinician, including name of the measure, dates, results, and standardized scores providing scores of each domain. Examples of these assessment tools include the current version of the:
 - ✓ Vineland Adaptive Behavior Scales
 - ✓ Adaptive Behavior Assessment System (ABAS)
- Expanded laboratory evaluation, if indicated
- Documentation that the client's behaviors or skill deficits are having an adverse impact on development or communication, or demonstrating injurious behavior, so that one of the following applies:
 - ✓ The client cannot adequately participate in home, school, or community activities because behavior or skill deficit interferes with these activities.
 - ✓ The client presents a safety risk to self or others. Examples include self-injury, aggression towards others, and destruction of property, stereotyped or repetitive behaviors, or elopement.
- Documentation that all of the following are met, if ABA services are ordered as part of the multidisciplinary treatment recommendations:
 - ✓ Less intrusive or less intensive behavioral interventions have been tried and were not successful.
 - ✓ There is no equally effective alternative available for reducing interfering behaviors, increasing prosocial behaviors, or maintaining desired behaviors.
 - ✓ The full range of autism treatments was considered, with ABA services as a treatment component, if clinically indicated.

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

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

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

Stage two of the pathway to care

WAC [182-531A-0600](#)

Selecting an ABA provider

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

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

1. The client meets with the ABA provider with a copy of their COE evaluation and order.
2. The LBAT completes an assessment of the child to:
 - Confirm medical necessity and readiness for treatment; and
 - Develop a treatment plan. In the case of Parent training only, the LBAT will complete only the parent treatment goals portion of the treatment plan with goals for the parent to achieve related to the child's assessment. Contact the specific managed care plan to determine the requirements for preauthorization of parent-only training.

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

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

The ABA assessment and treatment plan

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

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

- Background and history, which must include all of the following:
 - ✓ The client's age, gender, language, race and ethnicity.
 - ✓ Past psychiatric history.
 - ✓ Chief complaint and History of Present Illness (HPI).
 - ✓ Family history.
 - ✓ Social history.
 - ✓ Medical history.
 - ✓ Educational history.
 - ✓ Past and current services.
- Assessments completed for evaluation, which must include all of the following:
 - ✓ Measures used.
 - ✓ Evaluation findings.
 - ✓ Functional behavior assessment and analysis findings.
 - ✓ Goal domains derived from assessment.
- A brief overview of the treatment plan, which must include all of the following:
 - ✓ How ABA will be applied to the client (e.g., will include home and community based 1:1 intervention for twenty hours per week to target social, communication, and adaptive goals).
 - ✓ Whether a positive behavior support plan is required to address challenging behaviors.
 - ✓ Specific and measureable goals for the parent or caregiver to achieve.
 - ✓ How the treatment plan will be coordinated with other providers.
- A maintenance, generalization, and discharge plan. This plan must include a statement about how maintenance and generalization will be addressed, how services will be faded, or how the client will be transitioned into other less intensive services (such as school, outpatient). At intake, this statement may be broad, but should become more specific as the client progresses in therapy. The fading plan should be specific, data-driven, and include criterion for discharge.

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

- ✓ For day treatment program clients, the maintenance, generalization, and discharge plan should address all of the following:
 - Except in certain circumstances, children will be discharged from the program after 48 service days normally provided within a 12 week period.
 - Programs should begin discharge planning upon a child's admission in order to minimize the gap in services between programs due to waiting lists.
 - If there will be a gap in services (e.g., due to waiting lists) day treatment programs should attempt to provide follow-up consultation to the family on an outpatient basis, as needed, until community-based services are implemented.
- Goals and objectives for skill acquisition, which must include baseline or progress for each goal.

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

Stage three of the pathway to care

WAC [182-531A-0700](#)

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

LBAT responsibilities

WAC [182-531A-0800](#) (7)

The LBAT must do all of the following:

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

Note: If indicated, the LBAT may also complete all of the responsibilities of the CBT. See [CBT responsibilities](#).

CBT responsibilities

WAC [182-531A-0800](#) (10)

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

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

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

ABA delivery methods and settings

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

Community-based program services

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

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

Home and community services:

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

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

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

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

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

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

Purpose of the day treatment program

The purpose of the program is to build an initial foundation for supporting continuity of ongoing care through the assessment of a child's needs and targeting treatment goals that will promote the child's participation in other environments.

The program focuses on detailed assessment of learning needs, building learning readiness skills and independence, and providing family and caregiver support and education.

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

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

Providers in the day treatment program

WAC [182-531A-0600\(3\)\(a\)](#)

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

Requirements for the day treatment program

Coordination of care. The day treatment program must:

- Coordinate care with additional service providers (such as medication managers and providers conducting medical workup related to the diagnosis of autism and related disorders), if the services are not available within the program.
- Coordinate care with any outside service providers, assuming a release of information has been obtained (e.g., speech language pathology or occupational therapy providers).
- Coordinate care with schools or birth to three (B-3) programs when children are simultaneously receiving behavioral therapy services in these settings. A release of information is required.
- Coordinate advance discharge planning with providers outside the program who will be receiving the child for future services. Coordination with community-based ABA providers, schools, and B-3 programs is particularly important, as children are likely to be returning to care in these settings.

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

- Staffing ratio: A 1:1 staffing ratio required. This does not mean every child must have its own TA, but that the overall adult-to-child ratio is 1:1. Programs may have a CBT-to-child ratio of 1:1, but this will depend on what responsibilities other adults (e.g., lead therapist, lead teacher) in the room have.
- Staffing plan: The program must be staffed by at least one LBAT and enough CBTs who meet requirements under WAC [182-531A-0800](#) to meet the 1:1 staffing ratio.
- Use of trainees as program staff: Students and trainees (e.g., interns, post-doctoral fellows) can be integrated as paid program staff only if they meet the CBT requirements under WAC [182-531A-0800](#). Otherwise, students and trainees may provide direct care to children in the program as part of a supervised training experience; however, their time must not be billed to the agency.

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

- Program hours: Consistent with Washington state B-3 guidelines, children must attend the day treatment program a minimum of three hours per day, for enough days to total a minimum of twelve hours per week, for a total of 48 days. The child must be present for over half of the scheduled daily time in order for the program to bill for that day.
 - ✓ If a program wishes to serve children five days per week, the Medicaid agency covers a maximum of 15 hours per week (three hours per day, five days per week).
 - ✓ The day treatment program typically lasts 12 treatment weeks, or 48 service days.
 - ✓ The Medicaid agency may approve a child to remain in a day treatment program beyond 48 service days in circumstances that may compromise discharge planning (e.g., unresolved serious self-injury or aggression, family crisis, significant safety concerns, etc.).
- Teaching format: The day treatment program must have the capacity to individualize the need for 1:1 versus dyadic or group instruction as needed.
- Supervision: As required under WAC [182-531A-0800](#), an LBAT must supervise CBTs at a minimum of 5% of all therapy hours provided per week, per child. The LBAT must supervise all aspects of the clinic and remain on-site during all hours the day treatment program is in session.
- Specialty services:
 - ✓ Speech therapy: Speech therapy services must be available to support progress toward meaningful communication goals, as needed.
 - ✓ Parent and caregiver education and training: Parent and caregiver training must occur a minimum of once per week. Goals, format, and number of recommended hours per week should facilitate achievement of treatment goals and be included with the specific, measurable parent goals in the child's individual treatment plan.

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

What client files and records does the agency require?

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

- The prescription for ABA Services (if available)
- Any COE evaluations (if available)
- ABA assessments, functional behavior assessments or analysis, and treatment plans
- All collected client data and graphs
- Supervision notes
- Service log documenting that services were provided, dates and times of service, type of service, services provided, and location of where the services were provided
- Notes supporting parenting training, including but not limited to, sign-in sheets if service was provided in a group setting and description of content
- Notes supporting child's participation in group activities and interventions consistent with the treatment plan
- Documentation of coordination of services with other health care providers rendering services to the child or the child's family
- Daily documentation of the child's participation in the program, which must include all the following:
 - ✓ The child's name.
 - ✓ The date of service.
 - ✓ The amount of time the child spent in the program for the day.
 - ✓ Names of clinicians who worked directly with the child.
 - ✓ The goals targeted for the day and strategies used to pursue goals.
 - ✓ The intervention format (for example, individual or group therapy).
 - ✓ Graphed or numeric data that track the child's progress and participation for the day.
 - ✓ The signature, title and credentials of the person completing the daily documentation.

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

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

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

Example

Name: Susie Smith

Date: 12/12/13

Time statement: 180 minutes

Clinicians: Sally BCBA, LBAT and Donald LABA

Goals targeted/intervention format/treatment strategies and progress:

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

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

Telemedicine

What is telemedicine?

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

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

Originating site

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

Distant site

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

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

Which services may be provided via telemedicine?

WAC [182-531A-1200](#)

Telemedicine may be used to provide the following services:

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

The LBA may use telemedicine to supervise the CBT's delivery of ABA services to the client, the family, or both. LBAs who use telemedicine are responsible for determining if telemedicine

can be performed without compromising the quality of the parent training, or the outcome of the ABA therapy treatment plan.

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

What services are not paid for under telemedicine?

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

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

Note: For information on how to bill for telemedicine, see the [ABA Treatment fee schedule](#).

Authorization

WAC [182-531A-1100](#)

What is prior authorization (PA)?

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

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

Managed care clients should follow the prior authorization instructions for their specific plan.

When is PA required?

PA is required when:

- The client is a Washington Apple Health client (either fee-for-service or managed care).
- The client has a private insurance policy that provides a benefit for ABA services, and that benefit has been exhausted.
- The client has private insurance that does not provide a benefit for ABA services.
- The private insurance policy covers only a portion of the ABA therapy services, e.g., BCBA only.
- The client has Medicare.

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

What forms and documents are required for PA?

The ABA provider request for PA must include all of the following forms and documents:

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

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

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

- A copy of a signed prescription for ABA therapy services, if available**

- A copy of the COE evaluation, if available**

For information about downloading agency forms, see [Where can I download agency forms?](#)

Does PA for ABA services expire?

WAC [182-531A-1100](#)

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

For information on how to request continuation of ABA services, see [What are the requirements for recertification of ABA services?](#)

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

WAC [182-531A-1100](#)

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

To request authorization for additional units, follow these steps:

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

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

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

What are the requirements for recertification of ABA services?

WAC [182-531A-1100](#)

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

- The LBAT must request authorization to continue services at least three weeks before the current authorization expires.
- The LBAT must submit a reevaluation and revised ABA treatment plan that documents the client's progress, showing measurable changes in the frequency, intensity, and duration of the targeted behavior or symptoms addressed in the previously authorized ABA treatment plan. Documentation must include all of the following:
 - ✓ Projection of eventual outcome.
 - ✓ Assessment instruments.
 - ✓ Developmental markers of readiness.
 - ✓ Evidence of coordination with providers.

Additional requirements for recertification of ABA services

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

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

Why might the agency deny recertification of ABA services?

WAC [182-531A-1100](#) (5)

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

- Lack of medical necessity. For example:
 - ✓ The child fails to respond to ABA services, even after encountering different ABA techniques and approaches, if applicable.

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

What is a limitation extension (LE)?

WAC [182-501-0169](#)

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

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

- Behavior identification assessment, treatment plan development (0359T).
- Exposure behavioral follow-up assessment (0362T/0363T).

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

How do I obtain an LE?

For all LE requests, the following documentation is required:

- A *General Information for Authorization* form HCA 13-835 (See [Where can I download agency forms?](#)) that:
 - Is typed
 - Is the coversheet for the PA request
 - Includes additional units of service needed
 - Includes supporting justification of medical necessity
- Description of services provided and outcomes obtained in treatment to date

Coverage

WAC [182-531A-0900](#)

What is covered?

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

ABA treatment – home and community-based settings

Procedure Code	Short Description	PA	Comments
Functional Assessment and Analysis / Treatment Plan Development			
0359T	Behavior identification assessment		Limit 3 per year, per provider. LBAT only. Includes 0360T and 0361T
0362T	Exposure behavioral assessment		First 30 min; limit 3 per year, per provider. LBAT only.
0363T	Exposure behavioral assessment - additional		Limit 3 additional segments per assessment, according to CMS (MUE) guidelines; limited to 3 per year, per provider. LBAT only.
Program Modification			
0368T	Adaptive behavior treatment with modification		First 30 min; LBAT only
0369T	Behavior treatment with modification – additional		Per 30 min; LBAT only

Applied Behavior Analysis (ABA) Program
for Clients Age 20 and Younger

Team Conference			
99366*	Team conference with client		30 min or more
99368*	Team conference without client		30 min or more
Telemedicine			
Q3014	Telehealth originating site facility fee		Per completed transmission
Parent or Group Training			
0370T*	Family adaptive behavior treatment with modification		Per visit, 60-75 min sessions. LBAT per day
0371T*	Multi-family group adaptive behavior guidance		Per visit, 90-105 min sessions. LBAT per day
ABA Treatment in Home and Community-Based Settings			
0364T*	Adaptive behavior treatment	PA	First 30 min
0365T*	Adaptive behavior - additional	PA	Per 30 min
0366T*	Group adaptive behavior treatment	PA	First 30 min
0367T*	Group behavior treatment - additional	PA	Per 30 min
ABA Treatment – Day Program, Agency-Approved Clinic Setting			
H2020	Therapy behavior services, per diem	PA	Per diem
ABA Treatment – Day Program, Agency-Approved Outpatient Hospital Setting			
0373T	Exposure behavior treatment	PA	First 60 minutes
0374T	Expose behav treatment addl	PA	Additional 30 minutes
H2020 / 0509	Therapy behavior services, per diem	PA	Per diem

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

ABA treatment – group settings

Procedure Code	Modifier	Short Description	PA	Comments
Parent Training in a Group Setting*				
0371T	UN	Parent training – 2 families		Per visit
	UP	Parent training – 3 families		Per visit
	UQ	Parent training – 4 families		Per visit
	UR	Parent training – 5 families		Per visit
	US	Parent training – 6+ families		Per visit
ABA Group Treatment in Home and Community-Based Settings*				
0366T/0367T	UN	Skills train and devel – 2 clients	PA	Per 30 min
	UP	Skills train and devel – 3 clients	PA	Per 30 min
	UQ	Skills train and devel – 4 clients	PA	Per 30 min
	UR	Skills train and devel – 5 clients	PA	Per 30 min
	US	Skills train and devel – 6+ clients	PA	Per 30 min

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

What modifiers do providers bill with?

When providing two distinct services on the same day for the same client, the **XE modifier** must be used to distinguish them as distinct and occurring during a separate encounter. For example, use CPT 99366 or 99368 on the same day as CPT codes 0370T or 0371T.

When services are provided in a group setting, providers must add the following modifiers to CPT codes 0366T/0367T and 0370T/0371T:

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

What about services covered under other agency programs?

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

- Mental Health Services
- Dental Services

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

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

Which services are not covered?

WAC [182-531A-1000](#)

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

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

Billing

Effective for claims billed on and after October 1, 2016

All claims must be submitted electronically to the agency, except under limited circumstances.

For more information about this policy change, see [Paperless Billing at HCA](#).

For providers approved to bill paper claims, see the agency's [Paper Claim Billing Resource](#).

What are the general billing requirements?

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

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

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

Refer to the agency's [Fee Schedule](#) for the procedure codes and modifiers assigned to this program.

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

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

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

Hospital outpatient providers may access instructions on completing and submitting claims using the [ProviderOne Billing and Resource Guide](#).

How do I bill claims electronically?

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

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

Rendering and individual provider taxonomy numbers

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

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