

Washington Apple Health (Medicaid)

Applied Behavior Analysis (ABA) Program Billing Guide

April 29, 2022

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and a Health Care Authority (HCA) rule arises, the rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If this is the most recent guide, please notify us at askmedicaid@hca.wa.gov.

About this guide*

This publication takes effect **April 29, 2022** and supersedes earlier billing guides to this program. Unless otherwise specified, the program(s) in this guide are governed by the rules found in [Chapter 182-531A WAC](#).

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

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

Refer also to HCA's [ProviderOne billing and resource guide](#) for valuable information to help you conduct business with HCA.

How can I get HCA Apple Health provider documents?

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

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

Where can I download HCA forms?

To download an HCA form, see HCA's [Forms & Publications](#) webpage. Type only the form number into the Search box (Example: 13-835).

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What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the Subject column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
Definitions	Added definition for "Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5)"	To align with WAC changes effective 4/29/2022
What is ABA	Added language "and intellectual" throughout guide	To align with WAC changes effective 4/29/2022
What is a Center of Excellence (COE)	Removed language "hospital, medical center, or other health care provider" and replaced with "may be a facility/group or an individual provider"	To better align with description in WAC
What are the qualifications for a COE	Removed "and develop a multidisciplinary clinical treatment plan under WAC 182-531A-0500"	To align with WAC changes effective 4/29/2022

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Subject	Change	Reason for Change
How do providers enroll with HCA as a certified behavior technician (CBT)	Adjust language to align with WAC	To align with WAC changes effective 4/29/2022
Required documentation	Add "DC:0-5"	To align with WAC
Comprehensive diagnostic evaluation	Reworded section	Clarification to align with WAC 182-531A-0500(2) and (3)
The ABA assessment and treatment plan	Add language 60 days "from the date of the assessment and ABA therapy treatment plan"	To align with WAC changes
What is the early childhood intensive behavioral intervention day treatment program (day treatment program)	Added language, services are authorized "once in a client's lifetime for 48 service days."	To align with WAC changes
Which services may be provided via telemedicine	Added "caregiver" and "when otherwise not available in person."	To align with WAC changes
Does PA for ABA services expire	Added language "The ABA provider must request authorization for continuing services at least 15 calendar days prior to the expiration date of the current authorization."	To align with WAC changes
What are the requirements for recertification of ABA services	Updated the title of form 12-411 to "ABA Level of Support Requirement"	Clarification of form title

Subject	Change	Reason for Change
<p>Why might HCA deny recertification of ABA services</p>	<p>Added "absence of harmful behaviors (e.g., physical aggression to self or others or property destruction), if applicable." Added additional language for repeated noncompliance</p>	<p>To align with WAC changes effective 4/29/2022 Clarification</p>

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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 HCA forms, see Where can I download HCA forms?</p>
Becoming a provider or submitting a change of address or ownership	See HCA's ProviderOne Resources webpage
Contacting Provider Enrollment	See HCA's ProviderOne Resources webpage
Finding out about payments, denials, claims processing, or HCA managed care organizations	See HCA's ProviderOne Resources webpage
Electronic billing	See HCA's ProviderOne Resources webpage
Finding HCA documents (e.g., billing guides, fee schedules)	See HCA's ProviderOne Resources webpage
Private insurance or third-party liability, other than HCA-contracted managed care	See HCA's ProviderOne Resources webpage
Access E-learning tools	See HCA's ProviderOne Resources webpage
More information	See HCA's Autism and Applied Behavior Analysis (ABA) therapy webpage

Definitions

This list defines terms and abbreviations, including acronyms, used in this billing guide (See [Chapter 182-531A](#)). Refer to [Chapter 182-500 WAC](#) for a complete list of definitions for Washington Apple Health.

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

Examples of screening tools include:

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

Comprehensive treatment model – A model that meets a client'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.

Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5) – The developmentally based system for diagnosing mental health and developmental disorders in children birth through age five.

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

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

Program Overview

Who should read this guide?

This guide contains instructions for:

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

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

What is ABA?

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

What is the purpose of the ABA program?

Apple Health includes coverage for ABA services to address the core symptoms associated with autism spectrum disorders or other developmental and intellectual disabilities. ABA services support learning and assist with the development of social, behavioral, adaptive, motor, vocational, and cognitive skills. ABA services are considered medically necessary when other less intensive treatment has been unsuccessful, and the client's condition is known to be responsive to ABA based on current research.

Client Eligibility

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

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

How do I verify a client's eligibility?

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

Verifying eligibility is a two-step process:

- Step 1. Verify the patient's eligibility for Apple Health.** For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in HCA's [ProviderOne Billing and Resource Guide](#).
- If the patient is eligible for Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.
- Step 2. Verify service coverage under the Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see HCA's [Program Benefit Packages and Scope of Services](#) webpage.

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

1. By visiting the [Washington Healthplanfinder's website](#).
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 the [Washington Healthplanfinder's website](#) or call the Customer Support Center.

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

Yes.

Most Apple Health (Medicaid) clients are enrolled in one of HCA's contracted managed care organizations (MCOs). For these clients, managed care enrollment is displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an HCA-contracted MCO must be obtained through the MCO's contracted network. The MCO is responsible for:

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

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

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

Managed care enrollment

Most Apple Health (Medicaid) clients are enrolled in HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. Some clients may still start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Medicaid eligibility determination. Providers must check eligibility to determine enrollment for the month of service.

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.

Checking eligibility

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

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Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account:**

Go to [Washington Healthplanfinder website](#).

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

- Visit the [ProviderOne Client Portal website](#):
- Request a change online at [ProviderOne Contact Us](#) (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."
- Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

For online information, direct clients to HCA's [Apple Health Managed Care webpage](#).

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

Some Medicaid clients do not meet the qualifications for managed care enrollment. These clients are eligible for services under the fee-for-service Medicaid program.

Some examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption support and Foster Care alumni. If a client is enrolled in managed care for behavioral health services only, the fee-for-service program authorizes and pays for ABA.

Integrated managed care

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

Integrated Apple Health Foster Care (AHFC)

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

Clients under this program are:

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

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

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

Fee-for-service Apple Health Foster Care

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

American Indian/Alaska Native (AI/AN) Clients

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

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

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority’s (HCA) [American Indian/Alaska Native webpage](#).

What if a client has third-party liability (TPL)?

If the client has third-party liability (TPL) coverage (excluding Medicare), prior authorization must be obtained before providing any service requiring prior authorization. For more information on TPL, refer to HCA’s [ProviderOne Billing and Resource Guide](#).

Provider Eligibility

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 facility/group or an individual provider that meets or exceeds standards set by HCA for specific treatments or specialty care. In the ABA program, a COE performs the clinical diagnostic evaluation to determine whether ABA services are appropriate and medically necessary for an individual client. The COE provides the required diagnostic documentation, evidence of medical necessity, and an order for ABA services to HCA or the managed care organization (MCO).

What are the qualifications for a COE?

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

- A COE may be a person or an organization.
- The COE must be enrolled with HCA to receive payment from HCA.
- 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 as one of the following under [Title 18 RCW](#) who is experienced in the diagnosis and treatment of autism spectrum disorders and qualifies as a COE, whether or not that person is on the COE list:
 - A developmental pediatrician
 - A neurologist
 - A pediatric neurologist
 - A pediatric psychiatrist
 - A psychiatrist
 - A psychologist

For adults (clients age 21 and over), the COE provider must be a neurologist, psychiatrist, or psychologist.

Or

- A qualified medical provider who has been designated by HCA as a COE after completing identified continuing education, including specific COE training offered through Seattle Children's Autism Clinic, (for children only; this does not apply to adults (clients age 21 and over)).

The COE must be prequalified by HCA as meeting or employing people who meet all of the following criteria, whether the client is fee-for-service or enrolled in a managed care organization:

- ARNPs and physicians, including naturopaths, 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

AND must:

- Understand the medically necessary use of ABA services
- Be qualified to conduct and document a comprehensive diagnostic evaluation

How does a provider become recognized as a COE?

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

Training is offered in various locations for physicians, ARNPs and interested community members based on interest and trainer availability. See the [Washington State Medical Home Partnerships Project webpage](#) to request COE training or if your region is interested in hosting a COE training.

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

In limited circumstances HCA may, at its discretion, accept an evaluation from a qualified medical provider who is not a recognized COE. For HCA 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 HCA.

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

Who can enroll to provide ABA services?

Health care professionals with the following credentials offered through the Department of Health (DOH) 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 HCA as a lead behavior analysis therapist (LBAT)?

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

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

Additional requirements for LBAT enrollment

LBATs must meet both of the following:

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

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

To enroll with HCA as a CBT, an applicant must be:

- Certified by DOH as a CBT in good standing with no credential restrictions; and

- Have a signed Applied Behavior Analysis (ABA) Attestation form, HCA 13-0008, regarding ABA training and experience on file with HCA.

Additional requirements for CBT enrollment

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

Becoming a facility-based day treatment program

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

Accessing ABA Services

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

HCA uses a three-part approach, creating a pathway of care to deliver ABA services for eligible clients. 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, clients or caregivers identify and select an ABA provider. If the client is enrolled in an MCO, clients or caregivers call the MCO and request a case manager.

Stage three: Delivery of ABA therapy services

Stage one of the pathway to care

Referral

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

- The client's primary care provider.
- Another licensed health care practitioner.
- A school-based health care professional.
- An early intervention health care professional.
- The client, the client's family or the client's caregiver.
- The client's managed care organization.

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

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

What does the COE do?

COEs provides a comprehensive diagnostic evaluation and develops clinical treatment recommendations that may include an order for ABA. If the COE concludes ABA is an appropriate treatment that will likely benefit the client, 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.

Required documentation

HCA requires that COE providers complete and submit all of the following:

- The report of the comprehensive diagnostic evaluation, including treatment recommendations
- The COE order
- The DSM-5 or DC:0-5 checklist

The comprehensive diagnostic evaluation

The comprehensive diagnostic evaluation to align with WAC [182-531A-0500](#) must include:

- Documentation of how the diagnosis of autism spectrum disorder or other intellectual/developmental disability (for which there is evidence ABA is effective) was made or confirmed by a COE provider that includes:
 - Results of formal diagnostic assessments performed by a clinician, including name of measure, dates, and results; or
 - Clinical findings and observations used to confirm the diagnosis.
- Documentation that the client's behaviors or skills deficits adversely affect development or communication or that the client demonstrates injurious behavior, such 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, destruction of property, stereotyped or repetitive behaviors or elopement.
- Documentation showing that all of the following are met if ABA services are ordered:
 - 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 evaluating and prescribing provider believes there is a reasonable expectation that the requested ABA services will result in measurable improvement in the client's behavior or skills.
- If the COE possesses a copy, the evaluation must include the following items:
 - Results of routine developmental screening.
 - Audiology and vision assessment results, 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 spectrum disorder (ASD) screening tool, including date completed and significant results.

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- Documentation of a formal cognitive or developmental assessment performed by the COE or another qualified clinician, including name of measure, dates, results, and standardized scores providing verbal, nonverbal, and full-scale scores. Examples of these assessments including:
 - Mullen Scales of Early Learning
 - Wechsler Individual Achievement Test
 - Bayley Scales of Infant and Toddler Development
- Documentation of a formal adaptive behavior assessment performed by the COE for developmental/intellectual disability or another qualified clinician, including name of measure, dates, results, and standardized scores; providing scores of each domain. Examples of these assessments include:
 - Vineland Adaptive Behavior Scales
 - Adaptive Behavior Assessment System (ABAS)

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

The COE will provide a copy of the comprehensive diagnostic evaluation and ABA order:

- To the ABA provider selected by the client/caregiver; or
- To the client/caregiver to forward to the selected ABA provider.

Stage two of the pathway to care

Selecting an ABA provider

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

Caregiver training only while the client is on a waitlist for individual ABA services

- The client meets with the ABA provider with a copy of their COE evaluation and order.
- The LBAT completes an assessment of the client to:
 - Confirm medical necessity and readiness for treatment; and
 - Develop a treatment plan. In the case of caregiver training only, the LBAT will complete only the caregiver treatment goals portion of the treatment

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plan with goals for the caregiver to achieve related to the client'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 caregiver training provided after the client has been approved for the ABA benefit or any ABA services – whether that training is provided during the client's individual treatment or alone after successful completion of ABA Day Treatment.

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

The ABA assessment and treatment plan

After a client or the client's caregiver 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, or an equivalent form with the same content. See [Where can I download HCA 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 20 hours per week to target social, communication, and adaptive goals).
 - Whether a positive behavior support plan is required to address challenging behaviors.
 - Specific and measurable goals for the 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 client 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, clients will be discharged from the program after 48 service days normally provided within a 12-week period.
 - Programs should begin discharge planning upon a client'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.

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

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Stage three of the pathway to care

In Stage Three of the ABA pathway to care, ABA services begin. Once the provider receives prior authorization from HCA, 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

The LBAT must do all of the following:

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

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

CBT responsibilities

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

- Be supervised by an LBAT.
- Deliver services according to the ABA therapy treatment plan, whether in an individual or group setting.
- Encourage family members to use their training to support generalization and maintenance of achieved behaviors.
- Ensure family involvement through modeling and coaching.
- Review the client's progress with the LBAT at least every two weeks to confirm that the ABA therapy treatment plan still meets the client'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

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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 client. ABA services can also be delivered in a variety of settings, depending on the program, the provider, and the client'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.

ABA services:

- May be used after discharge from a day services program.
- Provide a developmentally appropriate ABA therapy treatment plan for each client.
- Require recertification of medical necessity through continued authorization.
- Include family or guardian education, support, and training.
- Includes interventions designed to promote the client'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 childhood intensive behavioral intervention day treatment program (day treatment program)?

The early childhood 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). Typically, day treatment services are authorized once in a client's lifetime for 48 service days. A limitation extension may be requested if there is an occasional need to repeat the program

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due to extenuating circumstances. HCA does not authorize day treatment program services at the same time as adaptive behavior protocol (CPT® 97153).

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 caregiver education.
- The program uses a positive behavior support framework to address disruptive behavior problems.

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

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 and discharge planning. The day treatment program must:

- Coordinate care, which consists of phone or in-person contact with outside providers for whom the client has signed a release of information form.
Documented phone or in-person communications with caregivers that focus

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on care coordination and records review are also part of care coordination and discharge planning. Care coordination and discharge planning must occur with the appropriate frequency to meet the child's and the family's individualized needs.

- Coordinate care regarding the diagnosis of autism and related disorders with additional medical providers, such as medication managers and others conducting medical workups (e.g., dentists, audiologists, or neurologists), as needed.
- Coordinate care with schools when children are simultaneously receiving services in these settings. A release of information is required.
- Coordinate care with providers outside of the day treatment program, such as mental health providers, speech and language therapists, and occupational therapists, as needed or appropriate, with necessary release forms.
- Coordinate advance discharge planning with providers outside the program who will be receiving the child for future services. Coordination with community-based ABA providers and schools is particularly important, as clients are likely to be returning to care in these settings.
- Coordinate with social workers, Child Protective Services, guardians ad litem, and other court or state involved parties who may also be relevant to care coordination activities.
- Provide a written discharge plan reviewed with the family during a discharge meeting.

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

- **Staffing ratio:** A 1:1 staffing ratio is required. This does not mean every child must have its own certified behavior technician (CBT), 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 educator, speech and language pathologist (SLP)) in the room have.
- **Staffing plan:** The program must be staffed by at least one lead behavior analysis therapist (LBAT) who meets the requirements of [WAC 182-531A-0800](#). CBTs working in the program must also meet the requirements of [WAC 182-531A-0800](#).
- **Use of trainees as program staff:** Students and trainees working in the program must be enrolled in a formal academic program and appropriately supervised by the LBAT. Students and trainees may 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 clients in the program as part of a supervised training experience; however, their time must not be billed to HCA.

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

- **Program hours:** Children must attend the day treatment program at least more than half of the allotted three hours per day, for enough days to total twelve hours per week, for a total of 48 days.

- If a program wishes to serve children five days per week, HCA 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.
- HCA 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.
 - Caregiver education and training: 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 caregiver goals in the child’s individual treatment plan.

Day Treatment Program Model

Provider Type/ Service	Details
Certified Behavior Technicians	CBTs may be included in the 1:1 adult-to-child ratio for the program. CBTs will also need planning, data analysis, and supervision time. CBTs working in the program must meet the requirements of WAC 182-531A-0800.
Lead Behavior Analysis Therapist	The LBAT must supervise all aspects of the program 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 provided per week to an individual child.
Speech Therapy	Each child must receive direct, individualized speech therapy with a speech language pathologist (SLP) weekly (12 encounters across 48 treatment days to allow for make-ups), as indicated in the initial assessment.

Provider Type/ Service	Details
Caregiver Training	Caregiver training must consist of direct individualized training with an LBAT, which may be conducted in one-on-one, dyadic, or group sessions and must occur an average of once per week or 12 encounters across 48 treatment days to allow for make-ups. The clinic LBA or LABA will provide caregiver training. Guest “caregiver trainers” may be engaged by the LBAT based on the caregiver’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, behavioral challenges, toileting delays, 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 or other program staff will help families access and integrate outside services as needed, and coordinate discharge and transition services. Care coordination and/or discharge planning must occur a minimum of three times during the 48 treatment days or an average of once per month.

What client files and records does HCA require?

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

- The prescription or order for ABA Services
- COE evaluation
- 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 caregiver training, including but not limited to, sign-in sheets if service was provided in a group setting and description of content
- Notes supporting client’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 client or the client’s family
- Daily documentation of the client’s participation in the program, which must include all the following:
 - The client’s name.

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- The date of service.
- The amount of time the client spent in the program for the day.
- Names of clinicians who worked directly with the client.
- 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 client'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.

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 HCA 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 pivotal response treatment (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 and COVID-19

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.

For updated information regarding COVID-19, see HCA's [Information about novel coronavirus \(COVID-19\) webpage](#).

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 caregiver (for caregiver 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?

Telemedicine may be used to provide the following services:

- Program supervision when the client is present.
- Family/caregiver training, which does not require the client's presence.
- Speech language pathologist services during day treatment when otherwise not available in person.

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 caregiver 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 [Physician-Related Services/Professional Health Care Services Billing Guide](#).

Authorization

What is prior authorization (PA)?

Prior authorization (PA) is HCA'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](#).

Clients enrolled in an HCA-contracted managed care organization (MCO) must contact their designated MCO for program requirements.

Providers must submit PA for fee-for-service clients at least 15 days before they expect services to begin, or before current authorization expires. See [WAC 182-501-0165](#).

When is PA required?

PA is required when:

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

Note: If the client has a private insurance policy that provides a benefit for ABA services and the benefit has not been exhausted, PA is not required. If Washington Apple Health becomes the primary payer (for example, if the private policy's maximum benefit is reached or the parent loses private insurance), the client must go through HCA's prior authorization review 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.

Requesting prior authorization (PA)

When a procedure's EPA criteria has not been met or the covered procedure requires PA, providers must request PA from HCA. Procedures that require PA are listed in the fee schedule. HCA does not retrospectively authorize any health care services that require PA after they have been provided except when a client has delayed certification of eligibility.

Online direct data entry into ProviderOne

Providers may submit a prior authorization request by direct data entry into ProviderOne or by submitting the request in writing (see HCA's [prior authorization webpage](#) for details).

Written or Fax

If providers chose to submit a written or fax PA request, the following must be provided:

- The *General Information for Authorization* form, HCA 13-835. See [Where can I download HCA forms?](#) This form must be page one of the mailed/faxed request and must be typed.
- The program form. This form must be attached to the request.
- Charts and justification to support the request for authorization.

Submit written or fax PA requests (with forms and documentation) to:

- **By Fax:** (866) 668-1214
- **By Mail:** Authorization Services Office, PO Box 45535, Olympia, WA 98504-5535

For a list of forms and where to send them, see [requests for PA or LE](#). Be sure to complete all information requested. HCA returns incomplete requests to the provider.

Does PA for ABA services expire?

Yes. HCA grants authorization in three to six-month increments, or longer at HCA's discretion. The ABA provider must request authorization for continuing services at least 15 calendar days prior to the expiration date of the current authorization. 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?

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

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

1. Open HCA's document submission cover sheet [PA Pend Form](#).
2. Enter the 9-digit authorization reference number from HCA'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 HCA-contracted MCO, follow the guidelines of the MCO for additional units.

What are the requirements for recertification of ABA services?

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

- The LBAT must submit a new request for authorization to continue services at least three weeks before the current authorization expires. (See HCA's [Prior Authorization webpage](#) for details)
- The LBAT must submit a reevaluation and revised ABA treatment plan that documents the client's progress, showing measurable changes in the frequency, intensity, and duration of the targeted behavior or symptoms addressed in the previously authorized ABA treatment plan. Documentation must include all of the following:
 - Projection of eventual outcome.
 - Assessment instruments.
 - Developmental markers of readiness.
 - Evidence of coordination with providers.
 - Completed ABA Level of Support Requirement form, [HCA 12-411](#). Severe behaviors must be identified on the form. If there is aggression, it must be classified as physical, verbal, or property.

Additional requirements for recertification of ABA services

When deciding whether to authorize continued ABA services, HCA 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 caregiver conference, or request a second opinion before recommending continued ABA services. Providers must continue services pending recertification.

Why might HCA deny recertification of ABA services?

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

- Lack of medical necessity. For example:
 - The client fails to respond to ABA services, even after encountering different ABA techniques and approaches, if applicable.
 - Absence of harmful behaviors (e.g., physical aggression to self or others, or property destruction), 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.
- A demonstrated lack of engagement by the client, family, or caregiver in terms of keeping appointments, attending treatment sessions, attending scheduled family training sessions, completing homework assignments, and applying training as directed by the CBT or LBAT. Absences that are reasonably justified, such as illness, are not considered a pattern.

What is a limitation extension (LE)?

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

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

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

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

How do I obtain an LE?

Providers may obtain authorization for an LE request online through direct entry into ProviderOne (see HCA's [Prior Authorization webpage](#) for details). See WAC [182-501-0169](#) for information on limitation extensions.

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

- A completed, typed *General Information for Authorization* form (HCA 13-835) (See [Where can I download HCA forms?](#)).
The form must be the coversheet for the PA request and include:
 - Additional units of service needed
 - Supporting justification of medical necessity
- Description of services provided and outcomes obtained in treatment to date
- Expected outcome of extended services

Coverage

What is covered?

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

ABA treatment – home and community-based settings

Functional Assessment and Analysis/Treatment Plan Development

CPT® Code	Short Description	PA?	Comments
97151	Bhv id assmt by phys/qhp	No	LBAT 15-minute unit 28 units per assessment, 2 assessments per 365-day year
0362T	Bhv id suprt assmt ea 15 min	No	LBAT and 2 or more CBT's 15-minute unit

Telemedicine

HCPCS Code	Short Description	PA?	Comments
Q3014	Telehealth facility fee	No	Per complete transmission

Team Conference

CPT® Code	Short Description	PA?	Comments
99366	Team conf w/pat by hc prof	No	With client and/or family, face to face, 30 minutes or more
99368	Team conf w/o pat by hc pro	No	Without client or family, face to face, 30 minutes or more

Individual Treatment Codes

CPT® Code	Short Description	PA?	Comments
97153	Adaptive behavior tx by tech	Yes	CBT, 15-minute units Do not bill at the same time as H2020.
0373T	Adapt bhv tx ea 15 min	No	15-minute unit, LBAT and 2 or more CBT's client exhibits destructive behavior, provided in a customized environment
97155	Adapt behavior tx phys/qhp	No	15-minute unit LBAT and possible CBT

Caregiver Treatment Codes

CPT® Code	Short Description	PA?	Comments
97156	Fam adapt bhv tx gdn phy/qhp	No	15-minute unit LBAT
97157	Mult fam adapt bhv tx gdn	No	15-minute unit LBAT, two or more caregivers/families

ABA Group Home and Community-Based Treatment

CPT® Code	Short Description	PA?	Comments
97154	Grp adapt bhv tx by tech	Yes	15-minute unit Two or more clients
97158	Grp adapt bhv tx by phys/qhp	Yes	15-minute unit LBAT

ABA Intensive Day Treatment

HCPCS Code	Short Description	PA?	Comments
H2020	Ther behav svc, per diem	Yes	Per diem

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ABA treatment – group settings

Caregiver Training in a Group Setting*

CPT® Code	Modifier	Modifier Short Description	PA?	Comments
97157	UN	Parent training – 2 families	No	Per 15 min
97157	UP	Parent training – 3 families	No	Per 15 min
97157	UQ	Parent training – 4 families	No	Per 15 min
97157	UR	Parent training – 5 families	No	Per 15 min
97157	US	Parent training – 6+ families	No	Per 15 min

ABA Group Treatment in Home and Community-Based Settings*

CPT® Code	Modifier	Modifier Short Description	PA?	Comments
97154/97158	UN	Skill train and devel – 2 clients	Yes	Per 15 min
97154/97158	UP	Skill train and devel – 3 clients	Yes	Per 15 min
97154/97158	UQ	Skill train and devel – 4 clients	Yes	Per 15 min
97154/97158	UR	Skill train and devel – 5 clients	Yes	Per 15 min
97154/97158	US	Skill train and devel – 6+ clients	Yes	Per 15 min

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

What modifiers do providers bill with?

Use an appropriate modifier to delineate separate services by different providers at different times on the same day.

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

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

What about services covered under other HCA programs?

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

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

Note: HCA 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](#).

Which services are not covered?

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

- Autism camps
- Dolphin therapy
- Equine or Hippo therapy
- Primarily educational services

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

Billing

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

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

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

What are the general billing requirements?

Providers must follow the billing requirements listed in HCA'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 HCA must be loaded on the ProviderOne provider's file.

What codes do day treatment programs use to bill HCA?

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 HCPCS procedure code assigned to this program is H2020. Refer to HCA'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 HCA'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.

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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.