



United Behavioral Health

Supplemental Clinical Criteria Autism Services: Texas Medicaid

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INTRODUCTION & INSTRUCTIONS FOR USE

The following *State or Contract Specific Clinical Criteria*¹ defined by state regulations or contractual requirements are used to make medical necessity determinations, mandated for members of behavioral health plans managed by Optum and U.S. Behavioral Health Plan, California (doing business as OptumHealth Behavioral Solutions of California ("Optum-CA")).

Other *Clinical Criteria*² may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by Optum®³. These may be externally developed by independent third parties used in conjunction with or in place of these Clinical Criteria when required, or when state or contractual requirements are absent for certain covered services. When deciding coverage, the member's specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using these Clinical Criteria. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this Clinical Criteria and the member's specific benefit, the member's specific benefit supersedes these Clinical Criteria.

These Clinical Criteria are provided for informational purposes and do not constitute medical advice.

¹ **Clinical Criteria (State or Contract Specific):** Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.

² **Clinical Criteria**

(Level of Care Utilization System-LOCUS) Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make medical necessity determinations and placement decisions for adults ages 19 and older.

Child and Adolescent Level of Care Utilization System/Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) Standardized assessment tool developed by the American Association of Community Psychiatrists and the American Academy of Child and Adolescent Psychiatry used to make clinical determinations and to provide level of service intensity recommendations for children and adolescents ages 6-18.

(Early Childhood Service Intensity Instrument-ECSII) - Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make medical necessity determinations and to provide level of service intensity recommendations for children ages 0-5.

(ASAM Criteria) Criteria used to make medical necessity determinations for substance-related disorder benefits.

³ Optum is a brand used by United Behavioral Health and its affiliates.

Autism services are a benefit of the Texas Health Steps-Comprehensive Care Program (THSteps-CCP) for Medicaid clients who are 20 years of age or younger, and who meet the criteria outlined in this policy.

Autism spectrum disorder (ASD) is a condition characterized by restricted, repetitive patterns of behavior, interests, or activities and deficits in social communication and social interaction, with onset of symptoms occurring in early childhood.

Texas Medicaid acknowledges that research and clinical practices in interventions for ASD are an evolving and dynamic field. As such, documentation to support the medical need for ASD services, including applied behavior analysis (ABA) services, may include intervention techniques with a sound basis in discipline specific peer-reviewed literature when available, interventions with specific applicability to the person's clinical and functional profile (including co-morbid conditions), and an individualized, person-centered treatment plan that aligns with the values and preferences of the person with ASD and family.

Diagnosis

- Diagnosis of ASD may be made by any one of the following providers:
 - A developmental pediatrician
 - A neurologist
 - A psychiatrist
 - A licensed psychologist
 - An interdisciplinary team to include a physician, physician assistant, or nurse practitioner in consultation with one or more providers who are qualified child specialists who have expertise in autism limited to:
 - Any provider listed above
 - Licensed clinical social worker
 - Licensed professional counselor
 - Licensed psychological associate
 - Licensed specialist in school psychology
 - Occupational therapist (OT)
 - Speech-language pathologist (SLP)
- A comprehensive diagnostic evaluation, with each element conducted by appropriately trained, specialized and/or certified providers, is required to diagnose ASD. The diagnostic evaluation must include all of the following:
 - Diagnostic criteria and symptom severity level according to the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
 - A validated diagnostic assessment tool or combination of tools, using the most current editions or versions of the tools, as age and clinically appropriate, such as the Autism Diagnostic Observation Schedule, the Autism Diagnostic Interview-Revised (ADI-R), the Childhood Autism Rating Scale, or another validated diagnostic tool, as clinically appropriate.
 - Screening tools such as the Screening Tool for Autism in Toddlers and Young Children (STAT) may not replace the use of validated diagnostic assessment tools.
 - Documentation of diagnosis must include:
 - Age of the child/youth
 - Date of the initial ASD diagnosis
 - Documentation of any co-morbid behavioral or physical health disorders.
 - Documentation of trauma history.
- In order to be eligible for the ABA services outlined in this policy a diagnosis of ASD complete with diagnostic criteria and symptom severity level must be made or re-confirmed with re-assessment within 3 years of initiation or recertification of ABA services.
- In order to be eligible for ABA services outlined in this policy more than 3 years after initial ASD comprehensive diagnosis, re-assessment of ASD symptom severity levels per DSM criteria must be made by qualifying diagnostic providers, listed above.

Comprehensive Service Array

- Texas Medicaid offers an array of medically necessary services to support individualized treatment plans for children and youth up through 20 years of age with ASD.
- These services may be covered benefits when matched with an individualized treatment plan tailored to the specific needs of the child/youth birth through 20 years of age, their caregivers, and documented as medically necessary and effective. Not all services may be clinically appropriate for all people, families, or situations.
- Services must be evidence based, person-centered, delivered by personnel of appropriate training and credentialing, and oriented to functional, attainable, and measurable goals.
- Services must be evidence-based, person-centered, delivered by personnel of appropriate training and credentialing, and oriented to functional, obtainable, and measurable goals.
- These services include but are not limited to:
 - Applied behavior analysis (ABA)
 - Case management/care coordination (with parent permission)
 - Early Childhood Intervention (ECI)
 - Nutrition, when provided by a Licensed Dietitian
 - Occupational therapy (OT)
 - Outpatient behavioral health services
 - Physician services, including medication management
 - Physical therapy (PT)
 - Speech language pathology (also called speech therapy; ST)
- Non-physician, qualified health care professionals who are enrolled in Texas Medicaid may be reimbursed up to 2 times per year for participation in interdisciplinary team meetings for the coordination of care for children and youth with ASD aged birth through 20 years (procedure code 99366) who have a prior authorization for ABA evaluation or treatment services. The Licensed Behavior Analyst (LBA) is required to participate in interdisciplinary treatment team meetings. Interdisciplinary team meetings are not required for access to any service for children with ASD but are highly encouraged for a collaborative approach to treatment, which is considered the gold standard for care of people with ASD.
 - Interdisciplinary team meetings must include at least 3 licensed professionals meeting with the child/youth and/or family/caregiver simultaneously, one of which is the LBA.
 - Additional members may attend, such as assistants, paraprofessionals, others the family chooses, but these participants may not seek Medicaid reimbursement or count toward the required members of the interdisciplinary team meeting.
 - Non-Medicaid enrolled licensed professionals who would otherwise be eligible for reimbursement for interdisciplinary team meetings except that they are not Medicaid-enrolled who work directly with the child/youth may not receive Medicaid reimbursement for participation in team meetings. However, they may be considered as a participating team member for the purpose of meeting the minimum number of provider participants.
 - Regardless of Medicaid enrollment, licensed assistants, nonclinical social workers, case managers, and paraprofessionals may not count toward the minimum number of licensed professionals present at the interdisciplinary team meeting.
 - Team members may include Medicaid enrolled practitioners of the following disciplines:
 - Licensed Clinical Social Worker (LCSW)
 - Licensed behavior analyst (required team member)
 - Licensed Dietician (LD)
 - Licensed professional counselor (LPC)
 - Licensed Psychologist (LP)
 - Occupational Therapist (OT)
 - Physical Therapist (PT)
 - Speech-Language Pathologist (SLP)
 - Physician, Physician assistant or nurse practitioner
 - The physician, physician assistant, or nurse practitioner may bill a standard evaluation and management code (i.e., established patient visit) based on the counseling and coordination of care time spent in

the team conference.

- In order to be reimbursed for the interdisciplinary team meeting (procedure code 99366), each participating team member must have individually evaluated or provided direct services to the child/youth within the previous 180 days.
 - For a change of provider, the new provider must follow policy requirements [see Change of Provider section] to begin services prior to attendance at the interdisciplinary team meeting.
- Team members, including the child/youth and/or family/caregiver, may participate via remote technology which meets standards of care for telehealth.
 - Medicaid-enrolled providers must designate remote delivery with modifier 95 on the claim.
- Team members may include representatives from the child/youth's school, but school districts are not eligible for direct reimbursement for the interdisciplinary team meeting.
- No more than one individual from the same specialty may receive Medicaid reimbursement for the team meeting:
 - School personnel of the same discipline of Medicaid-enrolled providers participating to coordinate care are not considered duplicates of the same specialty and may count toward the 3 participant licensed professional minimum.

APPLIED BEHAVIOR ANALYSIS SERVICES

Applied Behavior Analysis (ABA)

- Behavior analysis is the scientific study of the principles of learning and behavior, specifically about how behavior affects, and is affected by, past and current environmental events in conjunction with biological variables.
- Applied Behavior Analysis (ABA) refers to the application of current, evidence-based specialized principles of the applied behavior analysis discipline by a provider, such as a licensed and certified behavior analyst (LBA), trained in this intervention.
- The intent of ABA therapy is to effect meaningful changes, which are durable and generalizable, in socially significant behaviors in everyday settings. ABA focuses on treating behavior difficulties and shaping behavior patterns through environmental adaptations and consistent reinforcement and consequences across settings and situations.
 - Intensive behavioral intervention (IBI) is a high intensity application of ABA therapy.
- ABA services must be medically necessary to treat, correct or ameliorate the individual's condition. A diagnosis alone is not sufficient documentation to support the medical necessity of ABA.
- Physical restraint is not appropriate during any service provided to Medicaid clients under the Autism Services benefit except in emergency instances of threat of physical harm to the child/youth or others around them.
 - Physical restraint may only be implemented by a person trained in the type of restraint being implemented.
 - Restraint must be limited to the use of such reasonable force as is necessary to address the emergency.
 - Restraint must be discontinued at the point at which the emergency no longer exists.
 - Restraint must be implemented in such a way as to protect the health and safety of the child/youth and others.
 - Restraint must not deprive the child/youth of basic human necessities.
 - Documentation must be kept of the up-to-date training for all staff members involved and of each incident that resulted in restraint.
- Use of ABA in no way precludes other medically necessary treatment interventions for ASD such as ST, OT, and other forms of behavioral therapy, family therapy, parent implemented models that use a developmental relationship-based approach and/or medication management.
 - Texas Medicaid strongly encourages, and in some circumstances requires, interdisciplinary collaboration of care.

Prior Authorization/Authorization Requirements

- Prior authorization is required for an ABA evaluation (procedure code 97151), an initial course of ABA treatment, and for subsequent recertifications for treatment (procedure codes 97153, 97154, 97155, 97156, 97158). Re-evaluations (procedure code 97151) for recertification of treatment require authorization.
- Essential elements for prior authorization are listed above in Submission Documentation section.
- Prior authorization/authorization requests may be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. The electronic signature technology must meet all applicable federal and state statutes and administrative rules. Electronically-signed documents must have an electronic date on the same page as the signature and electronic signatures that are generated through an electronic medical record (EMR) or electronic health record (EHR) system that complies with applicable federal and state statutes and rules are acceptable. All electronically-signed transactions and electronically-signed documents must be kept in the client's medical record. Prescribing and dispensing providers that utilize electronic signatures must provide a certification that the electronic signature technology that they use complies with all applicable federal and state statutes and administrative rules. Providers who submit a prior authorization/authorization request must also attest that electronic signatures included in the request are true and correct to the best of their knowledge. A hard copy of electronic transactions and signed documents must be available upon request. Stamped signatures and images of wet signatures will not be accepted. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization/authorization forms and supporting documentation using electronic or wet signatures.
- To complete the prior authorization/authorization process by paper, the provider must fax or mail the completed Comprehensive Care Program (CCP) Prior Authorization Request Form to the TMHP prior authorization unit and retain a copy of the signed and dated prior authorization form in the client's medical record.
- To complete the prior authorization/authorization process electronically, the provider must complete the prior authorization/authorization requirements through any approved electronic methods and retain a copy of the signed and dated prior authorization/authorization form in the client's medical record.
- To facilitate determination of medical necessity and avoid unnecessary denials, the prescribing provider and the LBA must provide correct and complete information, including documentation for medical necessity for the equipment or supplies requested. The physician must maintain documentation of medical necessity in the client's medical record.
- The prescribing provider or the LBA may be asked for additional information to clarify or complete a request.
- Retrospective review may be performed to ensure documentation supports the medical necessity of the requested services, equipment or supplies, as well as to determine compliance with all aspects of policy.

Timelines and Required Items

- The completed CCP Prior Authorization Request form and submitter certification statement are required with every submission for authorization or prior authorization.
- TMHP will accept the prescribing provider's signature on the CCP Prior Authorization Request form as a statement that the client's Texas Health Steps (THSteps) screenings are current and passed unless otherwise stated by the provider.

ABA Initial Evaluation

- To request prior authorization for an ABA initial evaluation, LBAs or prescribing providers must submit the following:
 - Documentation of comprehensive diagnostic assessment or reconfirmation of diagnosis for ASD signed and dated by the diagnosing physician, dated within 3 years prior to the date the PA request for ABA initial evaluation is received.
 - A completed Comprehensive Care Program (CCP) Prior Authorization Request Form, signed and dated by a prescribing provider within 60 calendar days prior to or on the anticipated evaluation date requested.

- The authorization for the initial ABA evaluation (procedure code 97151) is valid for 60 days from the requested evaluation date.
 - When the request for prior authorization is signed and dated after the requested evaluation date, dates of service prior to the prescribing provider's signature date will be denied.
- A request for prior authorization for an ABA initial evaluation must be submitted within 60 days prior to or on the requested evaluation date.
- When the request for prior authorization is submitted after the requested evaluation date, dates of service prior to the receive date will be denied.

Initial 90-day ABA Treatment

- To request prior authorization for an Initial 90-day ABA treatment, providers must submit the following:
 - Completed ABA evaluation and treatment plan signed and dated by the LBA.
 - An ABA evaluation is considered current when it is performed within 60 days prior to the start of care date on the prior authorization request form.
 - A completed Comprehensive Care Program (CCP) Prior Authorization Request Form, signed and dated by a prescribing provider within 60 calendar days prior to the requested ABA treatment start date, including the requested procedure codes and maximum units requested.
 - Providers may be authorized for units of procedure codes 97153, 97154, 97155, 97156, and/or 97158 for up to 90 days from the start date of service requested on the CCP Prior Authorization Request Form.
 - Providers must obtain authorization within 3 business days of the start of care (SOC) date for services that have not been prior authorized. During the authorization process, providers are required to deliver the requested services from the SOC date. Requests received after the 3-business day period will be denied for services prior to the date the request was received.
 - Late submissions: Requests for initial 90-day ABA treatment submitted 60 days after the completed ABA evaluation date and within 180 days after the evaluation date will require a progress summary signed and dated by the LBA.
 - For late submissions submitted after 180 days from the evaluation date, a re-evaluation must be completed.

ABA 90-day Treatment Extension

- To request prior authorization for an ABA 90-day treatment extension, providers must submit the following:
 - Attendance log which also includes a calculation of the percentage of scheduled sessions attended by the:
 - Child/youth and
 - Parent/caregiver for family education
 - Progress summary signed by LBA and parent/caregiver.
 - A completed CCP Prior Authorization Request Form, signed and dated by a prescribing provider within 60 calendar days prior to the start date of the ABA treatment extension request.
 - A 90-day recertification request is considered timely when it is submitted within 30 days prior to the end of the current authorization period. Providers may be authorized for units of procedure codes 97153, 97154, 97155, 97156, and/or 97158 for up to 90 days from the initiation of services.
 - A request for prior authorization that is submitted after the current authorization end date is denied for all dates of service prior to the date the request is received.

ABA Re-evaluation

- To request authorization for an ABA re-evaluation, providers must submit the following:
 - Completed ABA re-evaluation and treatment plan signed and dated by the LBA.
 - Re-evaluations do not require prior authorization (procedure code 97151). Re-evaluation will be reviewed for authorization upon submission.

- Providers must have a signed referral from the prescribing provider for an ABA re-evaluation in the client's file.
 - A re-evaluation may occur as early as 60 days prior to the end of the current authorization period.
 - An ABA re-evaluation is considered current when it is performed within 60 days before the end of the current authorization period.
- Procedure code 97151 should be listed on the CCP Prior Authorization Request Form with date span to include dates the re-evaluation was performed.

ABA 180-day Recertification

- Prior authorization for documented medically necessary recertification requests may be considered for increments up to 180 days for each request following the initial total of 180-days (two 90-day) authorization period(s).
- To request prior authorization for an ABA 180-day recertification, providers must submit the following:
 - Attendance log which also includes a calculation of the percentage of scheduled sessions attended by the:
 - Child/youth and
 - Parent/caregiver for family education
 - ABA re-evaluation and treatment plan signed by LBA.
 - An ABA re-evaluation is considered current when it is performed within 60 days before the current prior authorization end date.
 - A completed CCP Prior Authorization Request Form, signed and dated by a prescribing provider within 60 calendar days prior to the requested ABA treatment recertification start date, including the requested procedure codes and maximum number of units.
 - Providers may be authorized for units of procedure codes 97153, 97154, 97155, 97156, and/or 97158 for up to 180 days from the start date of service requested on the CCP Prior Authorization Request Form.
- Late submissions: Requests submitted 60 days after the completed ABA evaluation date and within 180 days after the evaluation, will require a review of current progress summary signed and dated by the LBA.
 - For requests submitted more than 180 days after the re-evaluation date, a new re-evaluation must be completed.
- A request for prior authorization for recertification of treatment that is submitted after the current authorization end date is denied for all dates of service after that end date and prior to the date the request is received.
- A complete request must be received no earlier than 60 days before the current authorization period expires.
- A gap in service is defined as not receiving ABA treatment or re-evaluation for 180 days or more. When a gap in service is identified, the provider must submit the request as an initial request and all documentation related with an initial request is required.

Discharge Criteria

- The ABA provider may discharge the child/youth from treatment or ABA prior authorizations may be discontinued when documentation submitted indicates one or more of the following:
 - The child/youth has met ABA treatment plan goals and is no longer in need of ABA services.
 - The child/youth has not made clinically significant progress toward meeting goals identified on the ABA treatment plan after successive progress review periods and repeated modifications to the treatment plan.
 - Healthcare services which do not demonstrate effectiveness as consistent with policy requirements must be modified or discontinued.
 - ABA treatment plan gains are not generalizable or durable over time and do not transfer to the larger community setting after successive progress review periods and repeated modifications to the treatment plan.
 - The child/youth can no longer participate in ABA services (for example, due to medical factors, family factors, or other factors that prohibit participation).
 - Parent/caregiver opts to discontinue.

- Attendance falls below 85% of scheduled sessions without documentation supporting the medical necessity of continued treatment.
- The ABA provider(s) do not appropriately collect, track, and/or review progress or outcomes data, and/or make appropriate treatment plan modifications for effective service delivery.

Service Delivery

Frequency and Duration

- Frequency must always be commensurate with the child/youth's clinical needs, level of disability, as well as evidence-based standards of practice; it is not for the convenience of the responsible parent/caregivers or the provider.
- LBA recommendations for frequency and duration on the ABA TP are expected to reflect the LBA's skilled analysis of the optimal dose-response relationship for the child/youth and family. Therefore, child/youth and family attendance at the recommended frequency and duration levels is critical in following evidence-based treatment recommendations. Poor or sporadic attendance may impact the effectiveness, durability, and/or generalizability of the treatments that are delivered.
 - An effective course of ABA typically requires active parent/caregiver involvement to increase the potential for durable and generalizable behavior changes in the specific behaviors identified as causing limitations or deficits in functional skills expected for the child/youth based on personal and environmental factors unique to that individual. Exceptions to this are made only as determined on a case-by-case basis.
- ABA may be delivered at the following frequency and duration levels without requiring additional submission of documentation and/or review by a physician for medical necessity. Medical necessity is related to symptom severity as defined by the current version of the DSM in addition to guidelines in policy. All levels of intensity of ABA treatment services may be considered depending upon individual case consideration. The following are guidelines. The objectives of ABA therapy will vary per child/youth, and frequency and duration should be based upon the functional goals of treatment, specific needs of the child/youth, response to treatment, and availability of appropriately trained and certified ABA staff. Treatment plans in which the requested frequency exceeds the following service level guidelines will be sent for physician review to determine medical necessity.
 - High frequency (IBI) (greater than 20 hours/week) may be considered when documentation shows two or more of the following:
 - Six years of age or younger
 - Autism Severity Level 2 or 3 (per DSM-V criteria)
 - Goals related to elopement, aggression, or self-injury that are severely impairing
 - Within the first 2 years of initiating ABA
 - Moderate frequency (6 to 20 hours/week) may be considered when documentation shows two or more of the following:
 - 12 years of age or younger
 - Autism Severity Level 2 or 3 (per DSM-V criteria)
 - Goals related to elopement, aggression, or self-injury that are moderately impairing
 - Within the first 4 years of initiating ABA therapy
 - Targeted/focused frequency (up to 5 hours or less/week or 20 hours or less/month in some other increment) may be considered when documentation shows two or more of the following:
 - 20 years of age or younger
 - Autism Severity Level 1, 2, or 3 (per DSM-V criteria)
 - Focused on specific targeted clinical issues or goals related to specific targeted skills
 - Maintenance/consultative level (2-4 hours per week or less) may be considered when documentation all of the following:
 - Ages 1-20 years of age
 - Autism Severity Level 1, 2, or 3 (per DSM-V criteria)
 - Goals related to integration of specific skills into daily functioning, and

- Documentation substantiates the risk for regression after completion of more intense ABA intervention

Parent/Caregiver Involvement

- For fidelity to the ABA treatment model for children and youth who meet eligibility requirements, an effective course of ABA typically requires active parent/caregiver participation and involvement to increase the potential for behavior changes in the specific behaviors identified as causing limitations or deficits in functional skills expected for the child/youth.
 - Parent/caregiver training is considered a separate component of the individualized treatment plan from the direct services provided to the child/youth and documentation of parent progress on goals is required.
- Parent/caregivers ideally must be able to participate in ABA therapy and implement ABA techniques in the home and community environment as instructed by the LBA and/or licensed assistant behavior analyst (LaBA) for behavior changes to prove to be durable and generalizable. Individual family circumstances are necessary criteria when designing the individualized treatment plan.
- Participation by the parent(s)/caregiver(s) is expected, and continued authorization for ABA services will take consideration of their involvement and ability to reinforce behavior changes over time and across settings.
 - Exceptions to this general expectation may be considered on a case by case basis. For example, for children and youth in residential placement through the Department of Family and Protective Services conservatorship with a treatment plan designed to address this limitation. In these cases, persons involved in the child/youth's care are encouraged to be involved in implementation of the therapeutic interventions in the home and community.
 - ABA services will not be denied solely on the basis of lack of parent/caregiver involvement; however, parent/caregiver involvement may affect the effectiveness, durability and generalizability to natural settings of the treatment and may be considered when making determinations regarding effectiveness of the treatment requested.

Treatment Planning

- Treatment planning requires that the LBA collaborate with and obtain documentation of determinations from the prescribing provider or other appropriate providers for elements of the treatment plan which are not within the LBA scope of practice.
- ABA treatment plans, including group treatment, require goals that relate to the child/youth's individual functional contexts.
- Functional context refers to everyday environments for behaviors or skills that allow the child/youth to achieve an outcome relevant to his/her health, safety, or independence.
 - Goals to address behaviors that result in deficits in social communication and social interaction relating to the child/youth's health, safety, or independence in functional contexts may be considered medically necessary.
 - Treatment plan goals (to include parent/caregiver training) may target a specific behavior interfering with activities of daily living (ADLs) and use the principles of ABA (i.e., backward chaining, schedules of reinforcement, etc.) to teach parents on supporting ADLs.
 - General goals addressing ADL skill acquisition are excluded.
- Functional goals must be specific to the child/youth, objectively measurable within a specified time frame, attainable in relation to the child/youth's prognosis and developmental status, both important to and relevant to child/youth and family, and directly related to the core symptoms of ASD as defined by the current version of DSM.
- The treatment plan may also include goals to specifically address challenging behaviors, such as aggression, in the creation of a Behavior Support Plan (BSP).
 - BSPs may not include the use of aversive interventions, including but not limited to the use of pain, discomfort, social humiliation, seclusion, or restraints.
- The treatment plan must include separate goals specific to parent/caregiver training.
- The child/youth must be able to participate in sessions as outlined in the individualized treatment plan.

- This policy addresses ABA services provided by Texas LBAs as well as by a Licensed assistant Behavior Analyst (LaBA) or behavior technician (BT) working under the supervision of an LBA in office, home, clinic, and community settings.
- All LBAs and their supervisees must provide services in a way that is consistent with the physician's orders, commonly accepted practice standards, licensing requirements, and within their scope of practice. Services must be provided in compliance with requirements of Medicaid, the Texas Health Step Comprehensive Care Program, medical standards for telehealth, and the Medicaid Autism Services policy, which may be more restrictive than general ABA practice. The LBA must determine if services are clinically appropriate, effective and not contraindicated for the child/youth, family, or particular situation. LBAs and supervisees must also adhere to all applicable health care standards, including, but not limited to, confidentiality, documentation, and medical record-keeping.
 - ABA therapy addresses the behaviors associated with the core symptoms of ASD that impact attainment of individualized functional goals. It is out of scope for an ABA provider to attempt to remediate underlying or associated medical conditions that may impact progress toward individualized functional goals or to formulate a treatment plan without appropriate collaborations with other healthcare disciplines, as appropriate.
 - LBAs and the staff they supervise are expected to have training and knowledge of typical development for children/youth 1 through 20 years of age in order to provide medically necessary services.
- When evaluating and treating children and youth with suspected or diagnosed co-morbid genetic, physical or behavioral health conditions or trauma history, the LBA is expected to coordinate with the appropriate skilled and licensed professionals. Co-occurring conditions may mimic or exacerbate ASD symptoms.
 - Diagnosis and treatment of physical health conditions, including developmental delays in children, would require collaboration with additional professionals.
 - For example, a child/youth with a co-morbid diagnosis of a motor disorder who has treatment plan goals addressing speech or motor skill development would require coordination with SLP, OT, or PT as appropriate.
 - For example, a child/youth with a of a seizure disorder would require close coordination with the physician treating the condition.
 - A child with a co-morbid diagnosis of a feeding disorder who has treatment plan goals addressing feeding would require coordination with the appropriate medical provider to include but not limited to: dietitian, OT, or SLP.
 - LBAs are not permitted as the sole provider of a feeding treatment plan.
 - Diagnosis and treatment of co-occurring behavioral health conditions requires the input of and coordination with behavioral health professionals specifically trained and educated in this scope of practice.
 - For example, a child/youth with a comorbid diagnosis of anxiety would require coordination with the appropriate behavioral health provider.
- It is out of scope for an LBA to dictate the provision of other medically necessary treatments, including to require a child/youth and family to drop other services in order to access ABA.
- The following ABA services may be authorized for eligible children and youth diagnosed with ASD according to policy guidelines:
 - An initial ABA evaluation (procedure code 97151) to include development of an individualized treatment plan and a Behavior Support Plan (BSP) as appropriate.
 - An initial 90-day course of ABA treatment with medical necessity documentation from the ABA evaluation. Treatment may include the following with documented medical necessity:
 - Provision of one-on-one ABA services delivered directly by the LBA or delivered by the supervised LaBA and/or BT (procedure codes 97153, 97155).
 - Provision of group ABA services delivered directly by the LBA or delivered by the supervised LaBA and/or BT (procedure codes 97154, 97158).
 - One-on-one services delivered directly to the child/youth with ASD by a BT or LaBA must be delivered in person. Use of telehealth in one-on-one, direct service delivery with the child/youth by a BT or LaBA is prohibited.
 - Providing training to family member(s)/caregiver(s) by the LBA or delegated to the supervised LaBA in accordance with the child/youth's individualized

treatment plan (procedure code 97156). The child/youth with ASD is not required to be present for this family/caregiver training.

- A 90-day extension of medically necessary ABA treatment, with supportive documentation of the extension from submission of an attendance log which also includes a calculation of the percentage of planned sessions completed for child/youth and parent/caregiver, and progress summary.
- An ABA re-evaluation (procedure code 97151), to include an attendance log which also includes a calculation of the percentage of planned sessions completed for child/youth and parent/caregiver.
- A 180-day recertification of ABA treatment with medical necessity documentation from the ABA re-evaluation and related documents.
- All ABA treatment and evaluation services require a signed and dated referral from the child/youth's prescribing provider.

Provider Requirements

- Licensed Behavior Analysts (LBA) must meet all the following requirements:
 - Have a current, unrestricted, state issued license and meet all applicable Texas licensure requirements.
 - If applicable, employ directly or contract with LaBAs and/or BTs.
 - Have training and knowledge of typical development for children/youth 1 through 20 years of age.
- LBAs serve as direct supervisors of the LaBAs and BTs and must ensure that the quality of the ABA services provided by LaBAs and BTs meets the minimum standards promulgated by the applicable certifying body's recommendations, rules, and regulations as well as Medicaid requirements.
- LBAs are ultimately responsible for the delivery of care including the TP.
 - Direct supervision must be provided in accordance with Texas state licensure.
- Only direct supervision, where the LBA directly observes the LaBA and/or the BT providing services with the child/youth or the child/youth's parents/caregivers, will be reimbursed by Texas Medicaid (procedure code 97155). Indirect supervision, to include but not limited to, a review and discussion of case load, data collection procedures, and professional development, is not reimbursable under Texas Medicaid.
- ABA treatment will ideally be delivered in the primary language used at home or the primary language of the child/youth with ASD.
 - Translation or interpretation services, when and as required for effective service delivery, must be offered if providers are not able to deliver the treatment in the child/youth's primary language.
- The LBA is responsible for provision of services within Medicaid policy parameters and requirements.
- Licensed Assistant Behavior Analysts (LaBAs)
 - LaBAs must have a current, unrestricted state issued license and meet all applicable Texas licensure requirements.
 - A supervised LaBA working within the scope of their training, practice, and competence may assist the LBA in various roles and responsibilities as determined appropriate by the LBA and delegated to the LaBA, consistent with the Texas state licensure requirements and Medicaid requirements.
 - LaBAs must have training and knowledge of typical development for children/youth 1 through 20 years of age.
 - LaBAs may not enroll in Texas Medicaid.
- Behavior Technicians (BT)
 - At BT refers to a high-school graduate level paraprofessional who delivers ABA services under the supervision of a LBA or an LBA and an LaBA.
 - All BTs must have certification as one of the following:
 - Registered Behavior Technician (RBT®).
 - Board Certified Autism Technician (BCAT)
 - Applied Behavior Analysis Technician (ABAT®)
 - Behavior technicians may not enroll in Texas Medicaid.

- Behavior technicians may not use the term “therapist” in their job title when interacting with Medicaid-enrolled children/youth, families, or caregivers or with professionals who also serve the child/youth, such as school staff or physicians.
- BTs may not amend the treatment plan or interpret the treatment plan to family, caregivers, or professionals who also serve the child/youth, such as school staff or physicians.
- A BT may not conduct the ABA assessment or establish a child/youth’s ABA treatment plan.

Documentation Requirements

- All the following elements must be submitted with the authorization request. NOTE: “Days” refers to calendar days unless otherwise specified.
- Initial Evaluation for Authorization:
 - The referral for ABA services must be submitted with the authorization request and must contain documentation from the diagnosing and/or prescribing provider of:
 - Age of the child/youth and year of the initial ASD diagnosis.
 - Any co-morbid behavioral health and/or physical conditions, including trauma history.
 - Level of symptom severity as per DSM criteria under ASD.
 - Diagnosis of ASD must have been made within the past 3 years (or reconfirmation of diagnostic criteria and symptom severity if the initial diagnosis of ASD was made more than 3 years ago).
 - A signed and dated referral from the prescribing provider for an evaluation for ABA services.
 - This referral may originate from the primary care provider.
 - The referral may originate from the diagnosing provider who is a physician, APRN, or PA.
- Initiation of Treatment Authorization
 - All the following elements must be submitted with the authorization request.
 - A signed and dated referral from a physician outlining the frequency and duration of treatment based on recommendations made in the ABA evaluation as well as the prescribing provider’s own clinical judgement.
 - The LBA must coordinate with the prescribing or other appropriate physician to document elements for initiation of ABA treatment which are not within the LBA’s scope of practice.
 - To document medical necessity for ABA, the following elements are required in the ABA assessment documentation:
 - A complete developmental history including:
 - Relevant co-morbid conditions, including trauma history.
 - Vision and hearing or audiologic screening, as age and clinically appropriate.
Note: If age and clinically appropriate, passing Texas Health Steps required screenings are acceptable. Results of further evaluations may be required if those screenings indicated deficits.
 - One-on-one observations of the child/youth, including at least one natural setting.
 - Documentation of interviews with parents/caregivers to further identify and define lack of adaptive behaviors and presence of maladaptive behaviors, to include any linguistic or cultural factors that may impact treatment.
 - Family history.
 - Primary language used by the child/youth with ASD and family.
 - How long the child/youth has been receiving ABA services, if applicable (such as after a gap in treatment), and information on responses to those previous interventions.
 - Prognosis based on evidence from the evaluation regarding the individual’s capacity to make behavioral gains.

- Validated assessments of cognitive abilities and adaptive behaviors, such as the Vineland Adaptive Behavior Scales.
 - An estimate of the child/youth's cognitive abilities may be provided when a validated assessment of cognitive abilities is not possible due to the child/youth's level of ASD and/or behaviors.
 - Limited cognitive ability or other co-occurring disability does not preclude the child/youth from consideration for medically necessary ABA evaluation and treatment services provided the treatment plan is realistic for the child/youth.
 - A functional behavior assessment, related to specific behaviors of concern, to be addressed in a BSP, as clinically indicated.
- Individualized ABA treatment plan must include:
 - Identification of specific targeted behaviors/skills related to the child/youth's health, safety, or independence that will be addressed in treatment.
 - Treatment goals must directly relate to the core symptoms of ASD as defined by the DSM.
 - Goals and protocols must be selected by the LBA in collaboration with the parent(s)/caregiver(s), consistent with person-centered and family-centered practice.
 - Functional goals must be specific to the child/youth, objectively measurable within a specified time frame, attainable in relation to the child/youth's prognosis and developmental status, both important to and relevant to child/youth and family, and directly related to the core symptoms of ASD as defined by the DSM.
 - Baseline data for all behaviors and skills identified for intervention across settings (e.g., home, school, community) where treatment will occur.
 - A BSP, if appropriate.
 - BSPs must include an operational, behavioral definition of the target behavior excesses and deficits, prevention and intervention strategies, schedules of reinforcement, and functional alternative responses.
 - The planned frequency (intensity) and duration of treatment across all settings to reflect the severity of the impairments, goals of treatment, expected response to treatment, and specific individual variables, (including availability of appropriately trained and certified ABA staff) that may affect the recommended treatment dosage.
 - Refer to Frequency and Duration section for guidelines to determine medical necessity.
 - Measurable parent/caregiver goals pertaining to learning the basic behavioral principles of ABA and applicability of these behavioral interventions in the home and community.
 - The planned frequency and duration of parent/caregiver training. Participation by the parent(s)/caregiver(s) is expected, and continued authorization for ABA services will take consideration of their participation in at least 85% of planned sessions.
 - Parent/caregiver training must be conducted by an LBA or LaBA.
 - The formal design of treatment protocol instructions to the supervised LaBAs and/or BTs.
 - If group treatment is planned, the treatment plan must include clearly defined, measurable goals for the group therapy that are specific to the individual and his/her targeted behaviors/skills.
 - A plan to ensure maintenance and generalization of skills.
 - Clearly defined, measurable, realistic discharge criteria and a transition plan across all treatment environments.
 - A clear plan to coordinate care with other providers, and with school services.
 - This is contingent upon a signed release of information from parent or guardian. Documentation of parent or guardian refusal to sign consent should be documented in these situations but should not preclude access to treatment.

- ABA Assessments and treatment plans completed by the LBA must include:
 - The child/youth's name
 - Date of birth
 - Date the initial ABA evaluation and treatment plan was completed
 - Name of the referring prescribing provider
 - Signature with date by the LBA
 - Signature with date by the parent/caregiver
- Initial requests for ABA will be authorized for 90 days and may be extended for an additional 90 days contingent upon submission of an attendance log and progress summary that support an extension of treatment.
- Authorization of 90-day Extension of Initial ABA Authorization
 - All the following elements must be submitted with the authorization request.
 - Attendance log for child/youth and
 - Attendance log for parent/caregiver and
 - Progress Summary
- Attendance Log and Progress Summary
 - Attendance logs which include a calculation of the percentage of scheduled sessions successfully completed must be maintained for the child/youth receiving treatment and for responsible parent/caregiver participation. If attendance falls below 85% of approved hours per authorization period as outlined in the individualized treatment plan and parent/caregiver education plan, additional documentation must be submitted by the LBA to substantiate need for continued ABA services at the previously approved level.
 - Attendance logs will record all scheduled and completed sessions and the percent of scheduled sessions attended by child/youth and the parent/caregiver for their scheduled respective sessions.
 - Attendance logs must be submitted after the first 90 days of initiating ABA treatment.
 - Attendance logs must be submitted with each request for extension or recertification.
 - Children/youth and parents/caregivers are expected to have attended a minimum of 85% of their respective sessions agreed upon within the approved treatment plan to substantiate the need for continuing at the previously approved frequency and duration of ABA services.
 - Cases in which either the children/youth or the parent/caregiver have not met the 85% attendance expectation will require submission of explanatory information and will be sent for physician review to determine medical necessity for continued services at the previously approved frequency.
 - Progress Summary:
 - A progress summary is made in the format of a Treatment Note. It must be:
 - Submitted after the first 90 days of initiating ABA treatment.
 - Billed as procedure code 97155.
 - Signed by LBA.
 - Signed by the parent/caregiver.
- Documentation Required for Recertification of Treatment with ABA
 - Subsequent requests after the initial total 180-day authorization may be approved for an additional 180-day period.
 - Requests for recertification of ABA treatment must include:
 - Documentation the child/youth has received a diagnosis or reconfirmation of the ASD diagnosis within the previous 3 years.
 - Attendance log which includes a calculation of the percentage of scheduled sessions which were completed.
 - For recertifications, children/youth and parents/caregivers are expected to have attended a minimum of 85% of their respective sessions agreed upon within the approved treatment plan in order to continue at the previously approved frequency and duration of ABA

services. Recertification requests not meeting this requirement will require submission of additional documentation and must be sent for physician review.

- Re-evaluation.
- Re-evaluation
 - Re-evaluation may be performed no earlier than within the last 60 days of an authorization period.
 - A re-evaluation includes all of the following:
 - All components of an initial evaluation which are within the scope of practice of an LBA.
 - The LBA shall maintain documentation of all of the elements of the initial ABA assessment which have been conducted by or coordinated with another provider.
 - An updated BSP for the child/youth, if applicable.
 - Baseline, current, and interim data for all behaviors and skills identified for intervention to demonstrate degree of progress toward mastering the functional treatment goals.
 - Documentation to allow reviewers to assess if the child/youth's behavior and skills have improved to a clinically meaningful extent in at least two settings (e.g., home, community, with different family members or peers) and to demonstrate that the LBA appropriately recorded and tracked progress and made protocol modifications as needed for effective service delivery.
 - Individual considerations should be given on a case-by-case basis for those with unusual or complex circumstances that may impact functional goal achievement (for example, children/youth in residential placement through the Department of Family and Protective Services conservatorship).
 - The child/youth's treatment plan updated and modification of the treatment protocol, as appropriate, to include clearly defined, measurable, functional goals for addressing behaviors and ensuring maintenance and generalization of acquired skills.
 - Documentation of the child/youth's status using a reliable, valid, standardized assessment instrument.
 - Discharge plan, to include fading and generalization plan.
 - For children/youth with additional diagnoses/co-morbid conditions, LBAs must address impact of co-morbidities on ABA progress and collaborate with other disciplines as appropriate.
 - Date and time the re-evaluation and treatment plan update was completed.
 - LBA signature and date.
- LBA must submit documentation attesting that:
 - The family/caregiver/responsible adult has agreed to the treatment plan, including:
 - Frequency specified on the treatment plan.
 - All places of service specified on the treatment plan.
 - The specific goals and prioritization of the identified goals on the treatment plan aligns with child/youth and family values and preferences.
 - The provider has access to sufficient staff to deliver the treatment plan frequency, duration, and in all places of service specified to allow accurate assessment of attendance in scheduled sessions.

Client Record Documentation

- In addition to documentation requirements outlined in the Submission Documentation section, all services outlined in this policy are subject to retrospective review to ensure that the documentation in the child/youth's medical record supports the medical necessity of the service(s) provided as well as adherence to Medicaid policy.
 - This documentation does not need to be submitted for the purposes of prior authorization.

Comprehensive Diagnostic Evaluation

- All required elements of the comprehensive evaluation must be retained by the diagnosing provider in the child/youth's medical record.

Interdisciplinary Team Meeting

- For procedure code 99366, each rendering provider must document:
 - Start and stop time of team meeting (minimum 30 minutes)
 - Date of most recent evaluation or re-evaluation
 - Names, disciplines, and organizational affiliation of other attendees
 - Brief narrative of reports to parents/guardians/child/youth with ASD
 - Summary of decisions made
 - Action items
 - Signature and date of the provider.
- Licensed assistants, non-clinical social workers, or paraprofessionals may not represent their supervisors at interdisciplinary team meetings

Consent

- Formal documentation of signed consent to ABA treatment signed by the child/youth's legally authorized representative must be kept in the child/youth's file.

Treatment Note

- For procedure codes 97153 (individual treatment) and 97154 (group treatment), the following documentation must be kept on file by the treating provider and be available when requested:
 - Child/youth's name.
 - Date of service.
 - Start and stop time of each treatment session.
 - Treatment plan goals addressed, and progress noted, if applicable.
 - A summary of the covered ABA services attempted during the session to include the activities or interventions delivered during the session and time allotted for them.
 - This summary should include direct observation measures that record data during every treatment session to allow the LBA to graph data across time for analysis.
 - Rendering ABA providers must sign each entry with full signature and credentials.
 - Additional supervisory signatures must be made in accordance with state licensure requirements and professional standards of care for the delivery of medically necessary services.
- For procedure codes 97155 (individual treatment with protocol modification) and 97158 (group treatment with protocol modification) the documentation should include all required treatment note elements listed for procedure codes 97153 and 97154 as well as:
 - Description of protocol modification decision points (may include supervision of BT or LaBA for procedure code 97155)
 - Assessments of child/youth's progress or lack of progress
 - Plan, such as updated goals.

Change of Provider

- If a provider or client discontinues therapy during an existing prior authorized period and the client requests services through a new provider, outside the current group, they must start a new request for authorization and submit all documentation required for an initial evaluation, and also the following:
 - A change-of-therapy provider letter, signed by the responsible adult
 - The letter must document the date that the client ended therapy (effective date of change) with the previous provider, or last date of service
 - The name of the new provider and previous provider
- When a provider or client discontinues therapy during an existing prior authorization period and the client requests services through a new provider within a group of independently enrolled providers collaboratively working together, the new provider can use the same evaluation and plan of care.
 - The authorization period will not change when the provider changes in this situation.

Limitations/Exclusions

- The following services are non-covered benefits of Texas Medicaid:
 - ABA addressing academic goals.

- ABA addressing goals only related to performative social norms that do not significantly impact health, safety, or independence.
- Treatment other than at the maintenance or consultative level not expected to result in improvements in the child/youth's level of functioning.
- Services that do not require the supervision of or specific skills and judgement of a LBA to perform.
- Services that do not meet accepted standards of practice for specific and effective treatment of ASD Services in the school setting as a shadow, aide, or to provide general support to the child/youth.
- Equipment and supplies used during ABA services are not reimbursed separately; they are considered part of the services provided.
- ABA evaluation or intervention services provided by a clinic or agency owned or partially owned by the child/youth's responsible adult (e.g., biological, adoptive, or foster parents, guardians, court-appointed managing conservators, other family members by birth or marriage).
- ABA evaluation or intervention services provided directly by the child/youth's responsible adult (e.g., biological, adoptive, or foster parents, guardians, court-appointed managing conservators, other family members by birth or marriage).
- Experimental or investigational treatment.
- Services or items not generally accepted as effective and/or not within the normal course and duration of treatment.
- Services for the caregiver or provider convenience, for example, as respite care or limiting treatment to a setting chosen by provider for convenience.

REIMBURSEMENT/BILLING GUIDELINES

- If services billed exceed the limitations outlined in this policy, the claim will be denied, and may be appealed.
- Autism services are reimbursed in accordance with 1 Texas Administrative Code § 355.
- Direct treatment for the child/youth is limited to a total of 8 hours per day, inclusive of procedure codes 97153, 97154, 97155, 97158.
- The following modifiers may be required for ABA services:

Modifier	Description
HO	Licensed behavior analyst
HN	Licensed assistant behavior analyst
HM	Behavior technician
95	Telehealth

- For clients who are birth through 20 years of age, the limitations listed below may be exceeded with evidence of medical necessity.
- The following procedure cod will be authorized for a 30-day authorization period for ABA evaluation or re-evaluation:

<u>Initial Evaluation</u>		
Procedure Code	Limitations	Modifier Options
97151	Limited to 6 hours (24 units)	HO only

<u>Re-evaluation</u>		
Procedure Code	Limitations	Modifier Options
97151	Limited to 6 hours (24 units)	HO only

- The following procedure codes may be reimbursed for ABA individual treatment:
 - 97153 – no modifier required
 - 97155 – HO,HN modifier options

- The following procedure codes may be reimbursed for ABA group treatment services:

Procedure Code	Modifier Options
97154	No modifier required
97158	HO,HN

- The following procedure code may be reimbursed for ABA parent/caregiver/family education and training services:

Procedure Code	Modifier Options
97156	HO,HN

- The following procedure code may be reimbursed for interdisciplinary team meetings attended by qualified non-physician healthcare providers:

Procedure Code	Modifier Options
99366	No modifier required

- Each claim for procedure code 97151 requires the following modifier:

Modifier	Description
HO	Licensed behavior analyst

- Each claim for procedure codes 97155, 97156, and 97158 requires one of the following modifiers for ABA services:

Modifier	Description
HO	Licensed behavior analyst
HN	Licensed assistant behavior analyst

- Claims for procedure codes 97153 and 97154 may include the following modifiers for information purposes regarding Behavior Technician Level Services:

Modifier	Description
HO	Licensed behavior analyst
HN	Licensed assistant behavior analyst
HM	Behavior technician

- Reimbursement for procedure code 99366 is limited to the following diagnosis code and is contingent upon prior authorization of ABA evaluation, reevaluation, or treatment services:
 - Diagnosis code:F84.0 for the diagnosis of Autism.
- Texas Medicaid will not reimburse multiple ABA providers during one ABA session with a child/youth when more than one ABA provider is present (concurrent billing).
- Concurrent billing is excluded except when the family and the child/youth with ASD are receiving separate services and the child/youth is not present in the family session.
- Texas Medicaid will not reimburse for ABA treatment services when the child/youth and/or family is not present and engaged in a therapeutic relationship.
- Reimbursement for covered ABA procedure codes are for the direct service time. Pre and post work for the session are not reimbursed separately. Separate reimbursement for treatment planning, note documentation, report writing, or updating of charts and data sheet is prohibited (other than what is allowable under procedure code 97151).

- Some service delivery to children/youth and/or parents/caregivers may be delivered remotely. It is the LBA’s responsibility to ensure that remotely delivered telehealth services are within scope of practice, not contraindicated for the child/youth, family, or particular situation, are clinically appropriate and effective, and in compliance with Texas licensure and standards for telehealth as well as follow all Medicaid, Texas Health Steps-CCP and this policy’s requirements. ABA evaluation and treatment services may only be delivered via telehealth using synchronous audio-visual technology or a similar technology.

- The following procedure codes may be delivered via telehealth:

Procedure Code	Required Modifier to designate remote delivery
97151	95
97155	95
97156	95
97158	95
99366	95

- LaBAs and RBTs may not deliver any service remotely.
 - Reimbursable remote delivery services must include synchronous audiovisual interaction between the distant site provider and the child/youth or parent/caregiver in another location.
- Procedure code 97151 is intended for conducting and reporting initial evaluations and treatment plans as well as re-evaluations by the LBA once every 180 days.
- Procedure code 97151 is reimbursed per authorized units provided by an LBA.
 - Procedure code 97151 will be authorized for up to 24 units (six hours) for the initial request of ABA services to complete an initial ABA evaluation and develop a treatment plan, to include data analysis and report writing.
 - Procedure code 97151 must be used within 30 calendar days of the first date of service for procedure code 97151 and is not reimbursable unless evaluation was submitted for authorization of payment.
 - Procedure code 97151 is eligible for reimbursement upon submission and approval of completed evaluation or re-evaluation.
 - After the initial evaluation, procedure code 97151 will be authorized for up to 24 units (six hours) for re-evaluations for every subsequent authorization.
- Procedure code 97153 is intended to be used for direct one-on-one ABA services delivered per ABA treatment plan protocol to the child/youth.
 - Procedure code 97153 designates a service of the complexity level appropriate for the delivery by a BT.
- Procedure code 97155 is used by LBA (or as delegated to an LaBA) for direct one-on-one time with one child/youth to develop a new or modified protocol.
 - Procedure code 97155 may also be used to demonstrate a new or modified protocol to a BT, LaBA, and/or parents/caregivers with the child/youth with ASD present. The focus of this code is the skilled determination to make an addition or change to the protocol.
 - Procedure code 97155 may be used when directly supervising the BT or LaBA while working directly with the child/youth.
- Either procedure code 97153 or 97155 may be used to request total hours of direct individual ABA treatment for the authorization period. Providers may then bill the code that reflects the treatment delivered.
- Procedure code 97154 is intended to be used for direct group ABA services delivered per ABA treatment plan protocol to the child/youth.
 - Procedure code 97154 designates a service of the complexity level appropriate for the delivery by a BT.
 - A group includes at least 2 patients but no more than 8.
- Procedure code 97158 is used by LBA (or as delegated to an LaBA) for direct group time to develop a new or modified group treatment protocol.

- Either procedure code 97154 or 97158 may be used to request total hours of direct group ABA treatment for the authorization period. Providers may then bill the code that reflects the treatment delivered.
- Procedure code 97156 is used by the LBA (or as delegated to an LaBA) for guiding the parents/caregivers (with or without the child/youth with ASD present) to utilize the ABA treatment plan protocols to reinforce adaptive behaviors for durability and generalizability. LBAs may delegate parent/caregiver teaching to LaBAs working under their supervision. LaBAs may not deliver services remotely via telehealth.

Method for Counting Minutes for Timed Procedure Codes in 15-Minute Units

- All claims for reimbursement of procedure codes paid in 15-minute increments are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units should be rounded up or down to the nearest quarter hour. See table below.
- To calculate billing units, count the total number of billable minutes for the calendar day for the client, and divide by 15 to convert to billable units of service. If the total billable minutes are not divisible by 15, the minutes are converted to one unit of service if they are greater than seven and converted to zero units of service if they are seven or fewer minutes.
- For example, 68 total billable minutes/15 = 4 units + 8 minutes. Since the 8 minutes are more than 7 minutes, those 8 minutes are converted to one unit. Therefore, 68 total billable minutes = 5 units of service.

Units	Number of Minutes
0 Units	0 minutes through 7 minutes
1 Unit	8 minutes through 22 minutes
2 Units	23 minutes through 37 minutes
3 Units	38 minutes through 52 minutes
4 Units	53 minutes through 67 minutes
5 Units	68 minutes through 82 minutes
6 Units	83 minutes through 97 minutes
7 Units	98 minutes through 112 minutes
8 Units	113 minutes through 127 minutes

REFERENCES

Texas Health and Human Services. (2021). HHS Children's Autism Program. Texas HHS website: <https://hhs.texas.gov/services/disability/autism>.

Texas Medicaid Provider Procedures Manual. (2021). Texas Medicaid and Healthcare Partnership website: *Note: Medicaid Autism Services link to be added 02/01/2022 upon formal posting from the state*.

REVISION HISTORY

Date	Action/Description
February 01, 2022	• Version 1