



State of New Mexico
 Medical Assistance Program Manual
Supplement



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TO: ALL PROVIDERS PARTICIPATING IN THE NEW MEXICO MEDICAID PROGRAM

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SUBJECT: APPLIED BEHAVIOR ANALYSIS (ABA) GUIDANCE

This supplement provides guidance for the Applied Behavior Analysis program. This guidance is released as a supplement aside from the Behavioral Health (BH) Billing and Policy Manual. This guidance will be included in any future iteration of the BH Billing and Policy Manual.

APPLIED BEHAVIOR ANALYSIS (ABA)

3.1 Policy Overview

The Medical Assistance Division (MAD) pays for medically necessary, empirically supported, Applied Behavior Analysis (ABA) services for eligible recipients 12 months and older who have a well-documented medical diagnosis of autism spectrum disorder (ASD), and for eligible recipients who have well-documented risk for the development of ASD. ABA are techniques and principles used to bring meaningful and positive changes in behaviors. ABA is the science in which the principles of the analysis of behavior are applied systematically to improve socially significant behavior and experimentation is used to identify the variables responsible for behavior change.

Autism Spectrum Disorder (ASD) is a neurodevelopmental disorder as defined by the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD). ASD is a life-long disorder and as such requires ongoing supports and services that are necessary to develop, maintain and restore to the maximum extent practical the functioning of an individual. ABA treatments have proved effective for ameliorating symptoms, developing adaptive behaviors, and reducing maladaptive behaviors to enhance healthy, successful functioning and prevent deterioration and regression in patients with disorders that arise during the developmental period. Examples of adaptive behaviors include social, communication, cognitive, leisure, self-care, daily living, vocational, and personal safety skills. Maladaptive behaviors that have been treated effectively with ABA procedures include self-injury, property destruction, pica (ingesting inedible items), aggression, elopement (wandering), obsessive behaviors, hyperactivity, and fearful behaviors.

MAD further offers specialty care services for a recipient who meets one or more of the ABA Specialty Care Areas. The information provided to the recipients and members of the recipient's Family Set must be culturally responsive and understandable.

ABA services are complex and require highly trained practitioners to evaluate, assess and deliver services.

Requirements of the utilization are:

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

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

3.2 Related Policy

For recipients between the ages of 12 months to 21 years, ABA services are part of the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. ABA services are provided to a recipient as part of a multi-stage comprehensive approach consisting of evaluation, assessment, and treatment which stipulates that ABA services be provided in coordination with other medically necessary services (e.g., family infant toddler program services (FIT), occupational therapy, speech language therapy, mental health services, medication management, day habilitation, MAD waiver services). ABA services are part of the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program; see 8.320.2 and 8.320.6 NMAC. [CFR 42 section 441.57].

Review 8.302.2 NMAC for general billing instructions; specifically, how to bill for less than full units of service.

[http://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20302/8_3_02_2\(3\).pdf](http://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20302/8_3_02_2(3).pdf)

3.2.1 ABA Services Delivered Via Telemedicine

See 8.310.2 NMAC for a detailed description of telemedicine requirements.

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

The BICC, BACB, and New Mexico Regulation and Licensing Department (RLD) psychologist's practice board allows and supports the use of telehealth to deliver ABA services. MAD allows and encourages the utilization of telemedicine to deliver MAD ABA services to assist AEPs and AP agencies provide cost effective and home and community-based services to rural and frontier areas of New Mexico.

[http://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20308/8_3_08_9\(1\).pdf](http://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20308/8_3_08_9(1).pdf)

<http://www.hsd.state.nm.us/providers/rules-nm-administrative-code-.aspx>

3.3 Definitions

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

Autism Provider (AP)- an agency approved by MAD to provide Stage 2 and 3 ABA services. The AP agency contracts or employs Behavior Analysts (BA) to conduct the Behavior or Functional Analytic Assessment. Utilizing the assessment and the recipient's ISP recommendations, the BA develops an individualized ABA Treatment Plan.

At-Risk for developing ASD- a recipient ages 12 months to 36 months who presents with multiple risk factors as evidenced by developmental delays and/or deficits, characteristics often seen in children with ASD, and genetic status, but who may not meet the full diagnostic criteria for a diagnosis of ASD.

Autism Evaluation Practitioner (AEP) - a practitioner who meets the requirements to conduct the Medical Assistance Division (MAD) approved ABA Stage 1 Comprehensive Diagnostic Evaluation (CDE), Targeted Evaluation, or Targeted Risk Evaluation. The AEP completes Evaluation Reports and develops the Integrated Service Plan (ISP).

Autism Spectrum Disorder (ASD) - a neurodevelopmental disorder as defined by the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases(ICD); or (b) a condition diagnosed as autistic disorder, Asperger's disorder, pervasive development disorder not otherwise specified, Rett's disorder or childhood disintegrative disorder pursuant to diagnostic criteria published in a previous edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American psychiatric association (APA).

Behavior Analyst (BA) - a practitioner who is certified by the Behavior Analyst Certification Board (BACB) to be a Board-Certified Behavior Analyst (BCBA) or a Board-Certified Behavior Analyst-D (BCBA-D), or a practitioner who the BACB recognizes as a Qualifying Psychologist who are collectively referred to as BAs. The BA must be approved to supervise BACB Board Certified Assistant Analyst (BCaBA or BAA) or a BACB Registered Behavior Technician (RBT or BT) or a Behavioral Intervention Certification Council (BICC) Board Certified Autism Technician (BCAT), and provides MAD required supervision to a BAA/RBT/BCAT/non-certified BT, and mentors an entry level BA (Mentored BA) for two years. A BA must successfully complete a criminal background registry check and possess and maintain their license or BCBA certification.

Behavior or Functional Analytic Assessment - addresses needs associated with both skill acquisition and meaningful and positive changes in behaviors. The Behavior or Functional Analytic Assessment results in the individualized development of an ABA Treatment Plan (as appropriate for the ABA service model).

Board Certified Assistant Behavior Analyst (BCaBA®) (BAA) - a practitioner who is certified by the BACB and approved by his or her BA to supervise BT. A BCaBA must successfully complete a criminal background registry check and possess and maintain their BCaBA certification.

Behavior Analyst Certification Board (BACB®) - a national certification board for BAs, BCaBAs, and Registered Behavior Technicians (RBTs).

Board Certified Autism Technician® (BCAT®) - a practitioner who is certified by the Behavioral Intervention Certification Council. The BCAT is included in the term BT. A BCAT is supervised by a BA, and if approved, a BAA.

Board Certified Registered Behavior Technician (RBT) - a practitioner who is certified by the BACB. The RBT renders ABA Stage 2 and 3 services under the supervision of a BA or, if approved, a Supervising BAA. A RBT is included in the term BT.

Behavioral Intervention Certification Council® (BICC®) - a national certification council for BCAT practitioners.

Behavior Technician (BT) - a RBT, BCAT, or a non-certified behavior technician (time limited) practitioner who assists a BA in rendering ABA Stage 2 services and renders, under supervision, ABA Stage 3 services.

Comprehensive ABA - refers to one of the two approaches to the treatment of a recipient where there are multiple targets across most or all developmental domains that are affected by the recipient's ASD. For a recipient who meets the At-Risk Criteria, Comprehensive ABA services are available from age 12 months up to 3 years of age. For a recipient who has an AEP rendered diagnosis of ASD, Comprehensive ABA services are available from age 12 months up to compulsory school age.

Comprehensive Diagnostic Evaluation (CDE) - is a multi-informant and multi-modal evaluation process that allows for the careful evaluation of the presence of symptoms consistent with a diagnosis of ASD, and if a diagnosis is rendered, allows for the careful consideration of medically necessary services, including ABA. A CDE includes a thorough review of the recipient's behavior and development and includes interviewing the parents and caregivers. It may also include a hearing and vision screening, genetic testing, neurological testing, and other medical testing. This is a part of ABA Stage 1 services.

Family Set - includes all individuals who are assisting or engaged in the recipient's care, such as, but not limited to: recipient's family and caregiver, individual family service plan (IFSP) or individual educational plan (IEP) staff, vocational staff, respite care staff, specialized service providers, such as psychosocial rehabilitation (PSR), behavior management services (BMS), day habilitation, treating primary or specialty care providers, residential or institutional care staff.

Focused ABA - refers to one of the two approaches to the treatment of a recipient for a limited number of behavioral targets. It is available to recipients 12 months up to the age of 21 with an AEP rendered diagnosis of ASD.

Integrated Service Plan (ISP) - a detailed document which pulls together the results of the CDE into a plan which prioritizes all medically necessary services. Results of the CDE, Targeted Evaluation, or the Targeted Risk Evaluation are used to develop an ISP. An ISP is required under ABA Stage 1 services either as a separate document or as an embedded part of the Targeted Risk Report. An AEP may conduct a follow-up ISP without conducting a CDE or Targeted Evaluation when medically necessary. When a recipient who had a Targeted Risk Evaluation presentation markedly changes, the AEP will conduct a CDE and issue an initial ISP.

Level of Care (LOC) - the intensity of medical care provided.

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

Non-certified Behavior Technician means a non-certified RBT or BCAT who:

1. Is at least 18 years of age;
2. Possesses a minimum of a high school diploma or equivalent;
3. Successfully completed a New Mexico criminal background registry check;
4. Completed a minimum of four hours of training in ASD including but not limited to training about prevalence, etiology, core symptoms, characteristics, and learning differences prior to rendering ABA Stage 2 and 3 services;
5. Within the first 90-calendar days of approval as a Non-certified Behavior Technician, completed 40 hours of training in ABA (provided by a BACB approved trainer) that meets RBT or BCAT certification requirements;
6. Prior to rendering ABA services has completed at least 20 hours of the required RBT or BCAT trainings;
7. Within the first 180-calendar days of approval as a Non-certified Behavior Technician, completed all other requirements to be approved for a RBT or BCAT testing date (e.g., passing the identified competency assessment, submitting the necessary documentation to the BACB or BICC); and
8. Secures and hold a RBT or BCAT certificate within the first continuous six- months of approval as a Non-certified Behavior Technician.
9. If the non-certified BT failed to earn their certification within the allotted timeframe, the non-certified BT must not render ABA Stage 2 or 3 services until they are a certified as a RBT or BCAT.

Service Authorization (Stage 2 and 3):

The purpose of a service authorization is to approve ABA services as long as the recipient maintains a diagnosis of ASD and demonstrates medical necessity.

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

Once a recipient has a service authorization, then the prior authorizations are to assist a BCBA modify a treatment plan.

Prior Authorization Period (Stage 2 and 3):

The purpose of the Prior Authorization is to assist a BCBA to modify the recipient's treatment plan based on the recipient's current presentation. As ASD is a lifelong diagnosis, supports through ABA services are medically necessary throughout the eligible recipient's lifespan in varying intensity.

- For a recipient between 12 months to eight years, the Prior Authorizations are every six months during the Service Authorization period.
- For a recipient eight years and older, the Prior Authorizations are six months during the Service Authorization period.

Specialty Care Practitioner (SCP) - a practitioner who renders specialized ABA Stage 2 and 3 services to recipients who meet the criteria for Specialty Care services.

Targeted Risk Evaluation - is conducted for a recipient aged 12 months to 3 years who meets the At-Risk Criteria for developing ASD. The Targeted Risk Evaluation results in an ISP embedded in the Risk Evaluation Report. An AEP cannot conduct a Targeted Evaluation when the recipient only has a Targeted Risk Evaluation. If there is marked change in the recipient's presentation, the AEP conducts a CDE.

Third Party Assessor (TPA) - The MAD's contractor who complete utilization reviews for determination on ABA Stage 3 services, for Fee for Service (FFS) recipients.

Qualified healthcare professional (QHP) - The American Medical Association (AMA) defines a qualified healthcare professional (QHP) for purposes of reporting medical services as follows: “A ‘physician or other qualified health care professional’ is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.” Provider qualifications for each service are described below.

3.4 Identified Population

ABA Stage 1-3 services are provided to EPSDT-aged recipients 12 months to 3 years meeting the At-Risk Criteria and recipients 12 months and older with a diagnosis of ASD or under EPSDT.

Admission Criteria: Services are determined to be medically necessary when the eligible recipient meets one of the following two categories:

1. At-risk for ASD: An eligible recipient may be considered “At-Risk for ASD,” and therefore eligible for time limited, Comprehensive ABA Services if he or she does not meet full criteria for ASD per the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD), and when he or she meets all of the following criteria:
 - a. Is between 12 and 36 months of age; and
 - b. Presents with developmental differences and/or delays as measured by standardized assessment; and
 - c. Demonstrates some characteristics of the disorder (i.e., impairment in social communication and early indicators for the development of restricted and repetitive behavior); and
 - d. Presents with at least one genetic risk factor (e.g., the eligible recipient has genetic risk due to having an older sibling with a well-documented medical diagnosis of ASD; the eligible recipient has a diagnosis of Fragile X syndrome).

2. Diagnosed with ASD: An eligible recipient who has a documented medical diagnosis of ASD according to the latest version of the DSM or the ICD is eligible for ABA services if he or she presents with a CDE or targeted evaluation. Has a documented diagnosis of ASD at any time in their life from an AEP or Grace Exception Practitioner; and Services are determined to be medically necessary to ameliorate symptoms of autism, build adaptive behaviors, and/or reduce maladaptive behaviors to enhance the patient’s health, safety, and overall functioning and/or to prevent deterioration or regression as documented by the AEP or Grace Exception Practitioner

3.4.1 Screening and Referral

A positive screening is when the recipient is determined by the screener to have met the requirements to begin ABA Stage 1 services.

3.4.1.A Screening Tools

- a. A Level 1 ASD screener (e.g., Modified Checklist for Autism in Toddlers, Revised with Follow-Up; M-CHAT-R/F™ or Social Communication Questionnaire; SCQ) has been administered, and the screener yields a positive result.
- b. The referring party believes the screener results to be valid based on their direct observation or recipient’s development. Although not required, the referring party is encouraged to use a Level 2 screener (e.g., the

Screening Tool for Autism in Toddlers™; STAT™) or gather additional information through another clinical assessment mechanism whenever the Level 1 screener result is inconsistent with other clinical data.

3.4.1.B Screeners:

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

3.4.1.C Results of Screening

If the screening results are positive, a referring practitioner may then refer the recipient to an AEP for ABA Stage 1 services. The screener has three options: (i) the screening results do not lead to the suspicion of the recipient having ASD; (ii) the screening results do lead to the suspicion of the recipient having ASD, the recipient may then access ABA Stage 1 services; (iii) the recipient's screening results do lead to the recipient being at risk for developing ASD may then access ABA Stage 1 services. Once the recipient is diagnosed or is at-risk for ASD by an AEP, and the recipient discontinues Stage 2 and 3 services, upon reentry to Stage 2 services, the recipient is not required to be rescreened.

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

3.4.1.C(2) At-Risk Criteria

A recipient who meets the At-Risk criteria below may access ABA Stage 1 services. A recipient 12 months to 3 years who screening determines the recipient is at risk for developing ASD is referred to an AEP for an ABA Stage 1 At-Risk Evaluation Targeted/Risk evaluation (T1026 HK). The recipient must have:

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

3.5 ABA Stage 1 Services - Diagnostic Evaluation

Allowed Practitioners:

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

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

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

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

3.5.1 Qualifications:

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

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

3.5.2 Implementation of Evaluations

There are two types of evaluations available to a recipient who has a positive screening, except when exempted, see 3.2.4 E (3): CDE (T1026 TG) and Risk Evaluation Targeted/Risk evaluation (T1026 HK). It is the AEP's responsibility to provide information to the recipient or the recipient's Family Set that describes the current presentation of the recipient and all adjunct practitioners whose input is necessary to fully evaluate, write the report, and complete the ISP (T1026 TG/HI) which details and prioritizes medically necessary services to the recipient, including ABA services, when appropriate.

3.5.2.A -Comprehensive Diagnostic Evaluation (CDE) (T1026 TG)

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

may also include results of a hearing and vision screening, genetic testing, neurological testing, and other medical testing.

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

3.6 T1026 TG - CDE Adult or EPSDT Grace Exception

HSD acknowledges the limited number of AEPs statewide and that recipients often have their CDE (T1026 TG) or Targeted/Risk Evaluation (T1026 HK) scheduled years in advance. This exception allows an EPSDT-aged or an adult recipient to start ABA Stage 2 and 3 service in a timely manner. To avoid a delay in receiving stage 2 and 3 services, a recipient may be referred for ABA services with a presumptive diagnosis of ASD by any licensed provider whose scope of practice allows them to render a diagnosis of ASD to allow for a seamless transition of services. This diagnosis must have been received within three (3) years of referral to stage 2 or 3 services. The individual must have a scheduled date for a comprehensive diagnostic evaluation. The NMAC will be adjusted accordingly to reflect this change.

3.6.1 (CDE (T1026 TG) – CDE EPSDT Grace Exception

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

3.6.2 CDE (T1026 TG) - CDE Adult Exception

For an adult recipient, unless medically warranted, CDE (T1026 TG) is not required. The adult recipient may without Prior Authorization, access ABA Stage 2 services and once approved, ABA Stage 3. They must complete The Targeted/Risk evaluation (T1026 HK) and ISP (T1026 TG/HI) prior to the end of their first Service Authorization. At any point during the adult recipient's Service Authorization the recipient's presentation no longer matches their current Targeted/Risk evaluation (T1026 HK), and the AEP determines it is medically warranted to conduct Targeted/Risk evaluation (T1026 HK) or a CDE (T1026 TG), the adult recipient's clinical file must document the medical necessity for CDE (T1026 TG) or Targeted/Risk evaluation (T1026 HK). A new ISP (T1026 TG/HI) must be completed. An adult recipient may access ABA Stage 2 and 3 services once an ABA Stage 3 Adult Treatment Plan has been approved and the adult recipient has been diagnosed by their Grace Exception Practitioner at any time in their medical history and there is a confirmation of ASD by a subsequent

Grace Exception Practitioner within the last three years.

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

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

3.7 Documentation Requirements

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

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

3.7.1.(A)Multi-informant:

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

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

3.7.1.(B)Multi-modal:

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

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

- v. medical and neurological functioning.

3.7.2. CDE (T1026 TG) and ISP (T1026 TG/HI) Requirements

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

- a. Within 60 calendar days of completion of CDE (T1026 TG), the AEP must issue a thorough report that documents the evaluation process, evaluation results, and case conceptualization and formulation, with special consideration of the criteria for ABA services for the recipient. The CDE (T1026 TG) record must be signed by the AEP; and ISP (T1026 TG/HI) must be signed by the AEP, the recipient or the recipient's legal guardian. For each new CDE (T1026 TG), the AEP must issue an individualized ISP (T1026 TG/HI) and issue it within 30 calendar days (or no more than 45 calendar days) at the completion of CDE (T1026 TG).
- b. If the AEP determines that ABA services are clinically indicated, ISP (T1026 TG/HI) must include a statement that the AEP expects that the requested ABA services will likely result in measurable improvement in the recipient's ASD symptomatology, associated behavioral excesses and deficits, and/or overall functioning, and ABA services are therefore prescribed.
- c. ISP (T1026 TG/HI) must ensure that all areas of need are adequately addressed through ABA and other medically necessary services (e.g., speech-language therapy, occupational therapy, specialized physical, behavioral, and long-term care health follow-up).
- d. ISP (T1026 TG/HI) must indicate what each recommended service provider should address in the context of their therapeutic work (i.e., what domains of functioning and what specific behavioral excesses or deficits they should target and if appropriate what range of dosage of support the recipient may consider upon completion the Stage 2 evaluation. For example, 30-40 hours per week of ABA for a comprehensive program or 15-25 hours per week focused program for a member with a Level 2 diagnosis). As such, the AEP may include broadly constructed intervention goals, but should refrain from formulating specific objectives. Rather, the clinicians to whom the recipient is ultimately referred should be responsible for creating their own discipline and domain-specific treatment plans, which should include this level of detail.
- e. ISP (T1026 TG/HI) must support access to, and participation in, services afforded through the Individuals with Disabilities Education Act (IDEA), including Part C for infants and toddlers and Part B for pre-school-aged children.
- f. The AEP must ensure that, if services other than ABA are prescribed, they are aligned with ABA such that the anticipated benefits to the recipient can be realized. ABA alone has been shown to be less effective, and therefore it is necessary that the AEP design and document an ISP that includes complementary, rather than contraindicated, components.
- g. ISP (T1026 TG/HI) must be linked to findings from CDE (T1026 TG) and reflect input from the recipient (as appropriate for age and developmental level), appropriate Family Set member as well as school staff and behavioral health professionals involved in the recipient's care.
- h. ISP (T1026 TG/HI) development must include a realistic assessment of available resources as well as characteristics of the recipient that may affect the intervention positively or negatively.
- i. ISP (T1026 TG/HI) must be based on the recipient's current clinical presentation, while being mindful of the long-term vision for the recipient's potential.
- j. ISP (T1026 TG/HI) must address needs associated with the recipient's ASD-related symptoms, as well as symptoms associated with co-morbid conditions.
- k. Given that the needs of a recipient with ASD are characteristically numerous, ISP (T1026 TG/HI) must establish clear priorities such that the most significant skill deficits and behavioral excesses are targeted first, with significance defined by the pivotal nature of the skill and/or by the risk that the skill's absence or behavioral excess poses to the recipient or others.

Stage One Comprehensive Diagnostic Evaluation (CDE)

Billing in Partial Units of T1026 with any ABA modifier

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

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

- a. Providers are to calculate the percentage amount by multiplying the full amount by the percentage rendered, $\$100 \times 25\% = \25.00 . Enter on a CMS 1500 claim form F.
- b. Providers are to enter a full unit of HCPCS time code of T1026 with any ABA Modifier. Enter on CMS 15 claim form G.
- c. There are no Prior Authorization limits for HCPCS timed code T1026 with any ABA modifier until such time as otherwise instructed.

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

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

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

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

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

T1026 TG T1026 TG/HI

ABA Stage 1 - Initial and Whenever CDE (T1026 TG) is Completed

For a recipient who is 12 months up to 21 years of age whose AEP has completed CDE (T1026 TG) as an initial or new CDE, or for a recipient 21 years of age and older whose AEP has completed CDE (T1026 TG) as an initial or new CDE, the AEP must complete a ISP (T1026 TG/HI).

Maximum number of units per ISP (T1026 TG/HI): three 60-minute units.

Concurrent Billing:

For a recipient who is accessing ABA Stage 2 and 3 services these services may continue while the AEP completes ISP (T1026 TG/HI).

In Conjunction with ISP (T1026 TG/HI):

For a recipient who is accessing ABA Stage 2 and 3 services these services may continue while the AEP completes ISP (T1026 TG/HI).

T1026 TG

T1026 HK

Do Not Bill:

T1026 HK/HI

3.7.3 Targeted/Risk evaluation

3.7.3 (A) (T1026 HK)-Targeted Evaluation:

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

If a recipient has an evaluation completed within the past 24 months that meets CDE (T1026 TG) requirements that was conducted by an out of state non-AEP who meets the requirements of a AEP, but the evaluation is lacking a ISP (T1026 TG/HI), the AEP conducts Targeted/Risk evaluation (T1026 HK) for the purpose of developing the initial ISP T0126 TG/HI. The AEP is expected to use clinical discretion regarding the evaluation tools necessary to develop the ISP (T1026 TG/HI) that meets the recipient's needs. Targeted/Risk evaluation (T1026 HK) while focusing in on specific areas of the recipient's current presentation, requires the same considerations and use of multi-informants as clinically indicated in CDE (T1026 TG). This means that for the specific behaviors or lack of behaviors being evaluated, the AEP must use their clinical judgement to determine whether another practitioner's input is required to produce a valid Targeted/Risk evaluation (T1026 HK) and ISP (T1026 TG/HI).

3.7.2 (B) Targeted/Risk evaluation (T1026 HK) Targeted Evaluations and ESPDT Recipients 8 years to 21 years:

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

3.7.2 (C) Targeted/Risk evaluation (T1026 HK) -Targeted Evaluations and Adult Recipients 21 years and Older:

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

3.8 Targeted/Risk evaluation & ISP

3.8.1 CONDUCTING Targeted/Risk evaluation (T1026 HK) AND ISP (T1026 TG/HI)

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

3.8.1 (A) Multi-informant:

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

1. For an EPSDT-aged recipient, their educational or early interventionist providers; or
2. Recipient's physical, behavioral and long-term care health provider (e.g., speech-language pathologist, social worker, occupational therapist, physical therapist, psychologist, psychiatrist, behavior analyst);
3. Day habilitation services, PSR, Mi Via and DD waiver service providers.

3.8.1 (B) Multi-modal:

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

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

3.8.1 (C) Targeted/Risk evaluation (T1026 HK) and ISP (T1026 TG/HI) Requirements

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

1. Within 60 calendar days of completion of Targeted/Risk evaluation (T1026 HK), the AEP must issue a thorough report that documents the evaluation process, evaluation results, and case conceptualization and formulation, with special consideration of the criteria for ABA services for the recipient. The Targeted/Risk evaluation (T1026 HK) record must be signed by the AEP and the ISP (T1026 TG/HI) must be signed by the AEP, the recipient or the recipient's appropriate Family Set member. For each new

Targeted/Risk evaluation (T1026 HK) Targeted Evaluation, the AEP must issue an individualized ISP (T1026 TG/HI) and issue it within 30 calendar days (or no more than 45 calendar days) from the completion of Targeted/Risk evaluation (T1026 HK).

2. If the AEP determines that ABA services are clinically indicated, ISP (T1026 TG/HI) must include a statement that the AEP expects that the requested ABA services will likely result in measurable improvement in the recipient's ASD symptomatology, associated behavioral excesses and deficits, and/or overall functioning, and ABA services are therefore prescribed.
3. ISP (T1026 TG/HI) must ensure that all areas of need are adequately addressed through ABA and other medically necessary services (e.g., speech-language therapy, occupational therapy, specialized physical, behavioral, and long-term care health follow-up,).
4. ISP (T1026 TG/HI) must indicate what each recommended service provider should address in the context of their therapeutic work (i.e., what domains of functioning and what specific behavioral excesses or deficits they should target and if appropriate what range of dosage of support the recipient may consider upon completion the Stage 2 evaluation. For example, 30-40 hours per week of ABA for a comprehensive program or 15-25 hours per week focused program for a member with a Level 2 diagnosis). As such, the AEP may include broadly constructed intervention goals, but should refrain from formulating specific objectives. Rather, the clinicians to whom the recipient is ultimately referred should be responsible for creating their own discipline and domain-specific treatment plans, which should include this level of detail.
5. ISP (T1026 TG/HI) must support access to, and participation in, services afforded through the Individuals with Disabilities Education Act (IDEA), including Part C for infants and toddlers and Part B for pre-school-aged children.
6. The AEP must ensure that if services other than ABA are prescribed, they are aligned with ABA such that the anticipated benefits to the recipient can be realized. ABA alone has been shown to be less effective than a suite of complementary therapies, and therefore it is necessary that the AEP design and document an ISP that includes complementary, rather than contraindicated, components.
7. ISP (T1026 TG/HI) must be linked to findings from Targeted/Risk evaluation (T1026 HK) and reflect input from the recipient (as appropriate for age and developmental level), legal guardian, or other caretaker, as well as school staff and behavioral health professionals involved in the recipient's care.
8. ISP (T1026 TG/HI) development must include a realistic assessment of available resources as well as characteristics of the recipient that may affect the intervention positively or negatively.
9. ISP (T1026 TG/HI) must be based on the recipient's current clinical presentation, while being mindful of the long-term vision for the recipient's potential.
10. ISP (T1026 TG/HI) must address needs associated with the recipient's ASD-related symptoms, as well as symptoms associated with co-morbid conditions.

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

For Billing Instructions, see Risk Evaluation, page 14.

3.9 Targeted/Risk evaluation & ISP

3.9.1 (A) Conducting Targeted/Risk evaluation (T1026 HK) - Risk Evaluation

For an EPSDT recipient 12 months up to three years of age who met the MAD screening At-Risk Criteria, the AEP completes Targeted/Risk evaluation (T1026 HK) Risk Evaluation. Targeted/Risk evaluation (T1026 HK) Risk Evaluation may be conducted at any point during the recipient's Service Authorization as medically warranted

without Prior Authorization. The recipient's medical record must document the medical necessity for a new Targeted/Risk evaluation (T1026 HK) Risk Evaluation instead of CDE (T1026 TG). The AEP must complete an ISP (T1026 TG/HI) for each new Targeted/Risk evaluation (T1026 HK). If the AEP determines the medical necessity for a new Targeted/Risk evaluation (T1026 HK) at any point during the recipient's three-year Service Authorization, no Prior Authorization is required. The clinical record must document the medical necessity for a new Targeted/Risk evaluation (T1026 HK) rather than completing a CDE (T1026 TG). It is not unusual due to the young ages of the recipients for their presentation to change within their Service Authorization period enough to warrant new Targeted/Risk evaluation (T1026 HK). A T1026 TG/HI must be completed.

3.9.1. (B) T1026 TG/HI - Integrated Service Plan (ISP):

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

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

3.9.1.(C) Multi-informant:

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

- a. Recipient's educational or early interventionist provider, Early Head Start, childcare provider; or
- b. Recipient's physical, behavioral and long-term care health provider (e.g., Speech-Language Pathologist, Social Worker, Occupational Therapist, Physical Therapist, Psychologist, Psychiatrist, Behavior Analyst, etc.).

3.9.1. (D) Multi-modal:

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

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

3.9.1.(E) T1026 - HK Risk Evaluation and ISP (T1026 TG/HI) Requirements

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

- 1. Within 60 calendar days of completion of Targeted/Risk evaluation (T1026 HK), the AEP must issue a

thorough report that documents the evaluation process, evaluation results, and case conceptualization and formulation, with special consideration of the criteria for ABA services for the recipient. The Targeted/Risk evaluation (T1026 HK) record must be signed by the AEP; and the ISP (T1026 TG/HI) must be signed by the AEP and the recipient's legal guardian. For each new Targeted/Risk evaluation (T1026 HK) Risk Evaluation, the AEP must issue an individualized ISP (T1026 TG/HI) and issue it within 30 calendar days (or no more than 45 calendar days) at the completion of Targeted/Risk evaluation (T1026 HK).

2. If the AEP determines that At-Risk ABA services are clinically indicated, ISP (T1026 TG/HI) must include a statement that the AEP expects that the requested ABA services will likely result in measurable improvement in the recipient's possible ASD symptomatology, associated behavioral excesses and deficits, and/or overall functioning, and ABA services are therefore prescribed.
3. ISP (T1026 TG/HI) must ensure that all areas of need are adequately addressed through ABA and other medically necessary services (e.g., speech-language therapy, occupational therapy, specialized physical, behavioral, and long-term care health follow-up,).
4. ISP (T1026 TG/HI) must indicate what each recommended service provider should address in the context of their therapeutic work (i.e., what domains of functioning and what specific behavioral excesses or deficits they should target). As such, the AEP may include broadly constructed intervention goals, but should refrain from formulating specific objectives. Rather, the clinicians to whom the recipient is ultimately referred should be responsible for creating their own discipline and domain-specific treatment plans, which should include this level of detail.
5. ISP (T1026 TG/HI) must support access to, and participation in, services afforded through the Individuals with Disabilities Education Act (IDEA), including Part C for infants and toddlers and Part B for pre-school-aged children.
6. The AEP must ensure that, if services other than ABA are prescribed, they are aligned with ABA such that the anticipated benefits to the recipient can be realized. ABA alone has been shown to be less effective than a suite of complementary therapies, and therefore it is necessary that the AEP design and document ISP (T1026 TG/HI) that includes complementary, rather than contraindicated, components.
7. ISP (T1026 TG/HI) must be linked to findings from Targeted/Risk evaluation (T1026 HK) Risk Evaluation and reflect input from the recipient (as appropriate for age and developmental level), legal guardian, or other caretaker, as well as school staff and behavioral health professionals involved in the recipient's care.
8. ISP (T1026 TG/HI) development must include a realistic assessment of available resources as well as characteristics of the recipient that may affect the intervention positively or negatively.
9. ISP (T1026 TG/HI) must be based on the recipient's current clinical presentation, while being mindful of the long-term vision for the recipient's potential.
10. ISP (T1026 TG/HI) must address needs associated with the recipient's ASD-related symptoms, as well as symptoms associated with co-morbid conditions.

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

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

T1026 HK AEP

ABA Stage 1 – Targeted Evaluation or Risk Evaluation

Targeted Evaluation:

Maximum number of units per Targeted/Risk evaluation (T1026 HK): five 60-minute units.

At any point during the recipient’s Service Authorization when the recipient’s presentation no longer matches specific elements of their CDE (T1026 TG) and the AEP determines it is medically warranted to conduct Targeted/Risk evaluation (T1026 HK) Targeted Evaluation in lieu of completing a new CDE (T1026 TG), the recipient’s clinical file must document the medical necessity for Targeted/Risk evaluation (T1026 HK).

No prior authorization is required.

For the recipient under 21 years of age who has an initial CDE (T1026 TG), Targeted/Risk evaluation (T1026 HK) is completed prior to the end of their Service Authorization.

For a recipient 21 years and older, Targeted/Risk evaluation (T1026 HK) is completed prior to the end of their Service Authorization.

The AEP must complete ISP (T1026 TG/HI) with each Targeted/Risk evaluation (T1026 HK).

Do not complete Targeted/Risk evaluation (T1026 HK) with ISP update (T1026 HK/HI).

Risk Evaluation:

For a recipient 12 months up to 3 years of age who meet the MAD At-Risk Criteria, the AEP completes Targeted/Risk evaluation (T1026 HK). No Prior Authorization is required.

If the AEP determines the medical necessity for a new Targeted/Risk evaluation (T1026 HK) at any point during the recipient’s Service Authorization, no Prior Authorization is required; however, the recipient’s clinical file must document the medical necessity for a new Targeted/Risk evaluation (T1026 HK) Risk Evaluation rather than complete a CDE (T1026 TG). It is not unusual for the recipient’s presentation to change within their Service Authorization enough to warrant new Targeted/Risk evaluation (T1026 HK).

Maximum number of units per Targeted/Risk evaluation (T1026 HK): five 60-minute units.

The AEP must complete ISP (T1026 TG/HI) for each Targeted/Risk evaluation (T1026 HK).

Concurrent Billing:

NONE

In Conjunction with Targeted/Risk evaluation (T1026 HK):

For a recipient who is accessing ABA Stage 2 and 3 services, these services may continue while the AEP completes ISP update (T1026 TG/HI)

Do Not Bill:

T1026 TG

T1026 HK/HI

ABA Stage 1 - ISP Initial and Ongoing for Targeted or Risk Evaluation

ISP (T1026 TG/HI) may be completed at any point during the recipient's Service Authorization when the AEP completes a Targeted/Risk evaluation (T1026 HK). No Prior Authorization is required.

Maximum number of units per ISP (T1026 TG/HI): three 60-minute. units.

Concurrent Billing:

NONE

In Conjunction with ISP (T1026 TG/HI):

For a recipient who is accessing ABA Stage 2 and 3 services these services may continue while the AEP completes ISP (T1026 TG/HI).

T1026 TG

T1026 HK

Do Not Bill:

T1026 HK/HI

3.10 ISP Updates

3.10.1 Update to the ISP (T1026 HK/HI) -

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

3.10.1 (A) ISP update (T1026 HK/HI) Requirements

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

1. Within 30 calendar days the AEP's determination the recipient requires only ISP update (T1026 HK/HI) instead of new CDE (T1026 TG) or Targeted/Risk evaluation (T1026 HK) the AEP must issue a thorough report that documents the AEP's conceptualization and formulation of ISP update (T1026 HK/HI), with special consideration of the criteria for ABA services for the recipient. ISP update (T1026 HK/HI) must be signed by the AEP, the recipient or the recipient's appropriate Family Set member.
2. ISP update (T1026 HK/HI) must support access to, and participation in, services afforded through the Individuals with Disabilities Education Act (IDEA), including Part C for infants and toddlers and Part B for pre-school-aged children.
3. The AEP must ensure that, if services other than ABA are prescribed, they are aligned with ABA such that the anticipated benefits to the recipient can be realized. ABA alone has been shown to be less effective, and therefore it is necessary that the AEP design and document in ISP update (T1026 HK/HI) that includes complementary, rather than contraindicated, components.
4. ISP update (T1026 HK/HI) must be linked to findings from CDE (T1026 TG) or Targeted/Risk evaluation (T1026 HK) and reflect input from the recipient (as appropriate for age and developmental level), legal guardian, or other caretaker, as well as school staff and behavioral health professionals involved in the recipient's care.

5. ISP update (T1026 HK/HI) development must include a realistic assessment of available resources as well as characteristics of the recipient that may affect the intervention positively or negatively.
6. ISP update (T1026 HK/HI) must be based on the recipient's current clinical presentation, while being mindful of the long-term vision for the recipient's potential.
7. ISP update (T1026 HK/HI) must address needs associated with the recipient's ASD-related symptoms, as well as symptoms associated with co-morbid conditions.
8. Given that the needs of a recipient with ASD are characteristically numerous, ISP update (T1026 HK/HI) must establish clear priorities such that the most significant skill deficits and behavioral excesses are targeted first, with significance defined by the pivotal nature of the skill and/or by the risk that the skill's absence or behavioral excess poses to the recipient or others.

Billing Instructions for Targeted/Risk evaluation (T1026 HK) and HI ISP Update

T1026 HK and T1026 HK/HI AEP

ABA Stage 1 - ISP Update

For a recipient whose presentation changes from the current ISP (T1026 TG/HI) and the change does not necessitate a new CDE (T1026 TG) or a Targeted/Risk evaluation (T1026 HK), the AEP updates the recipient's ISP and bills ISP update (T1026 HK/HI). The clinical record must document the medical necessity for ISP update (T1026 HK/HI).

ISP update (T1026 HK/HI) may be completed at any point during the recipient's current Service Authorization period when medically warranted without Prior Authorization. The clinical record must document the medical necessity.

Maximum number of units per ISP update (T1026 HK/HI): two 60-minute units.

Concurrent Billing:

NONE

In Conjunction with ISP update (T1026 HK/HI):

For a recipient who is accessing ABA Stage 2 and 3 services, or if approved for the EPDST or Adult Grace Exemption who is receiving ABA Stage 2 and 3 services (as approved), these services may continue while the AEP completes ISP update (T1026 HK/HI).

Do Not Bill:

T1026 TG

T1026 HK -Targeted Evaluation or Risk Evaluation

T1026 TG/HI - ISP

3.11 ABA Stage 2 & 3: Assessment and Treatment Planning

| Billing Code | Descriptor |
|--------------|---|
| 97151 | Behavior Identification Assessment, administered by QHP, each 15 minutes of QHP's time face-to-face with patient and/or guardian(s)/caregivers(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan |
| 97152 | Behavior Identification Supporting Assessment, administered by one technician under the direction of QHP, face-to-face with the patient, each 15 minutes |
| 0362T | Behavior Identification Supporting Assessment, each 15 minutes of technicians' time face-to-face with patient, requiring four components: QHP on site; assistance of 2+ technicians; patient with destructive behavior; environment customized to patient behavior |
| 97153 | Adaptive Behavior Treatment by Protocol, administered by technician under the direction of a QHP, face-to-face with one patient, each 15 minutes |
| 0373T | Adaptive Behavior Treatment with Protocol Modification, each 15 minutes of technicians' time face-to-face with patient, requiring four components: QHP on site; assistance of 2+ technicians; patient with destructive behavior; environment customized to patient behavior |
| 97154 | Group Adaptive Behavior Treatment by Protocol, administered by technician under direction of QHP, face-to-face with 2+ patients, each 15 minutes |
| 97155 | Adaptive Behavior Treatment with Protocol Modification, administered by QHP, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes |
| 97156 | Family Adaptive Behavior Treatment Guidance, administered by QHP (with or without patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes |
| 97157 | Multiple-Family Group Adaptive Behavior Treatment Guidance, administered by QHP (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes |
| 97158 | Group Adaptive Behavior Treatment with Protocol Modification, administered by QHP face-to-face with multiple patients, each 15 minutes |

3.11.1 Allowed Practitioners

1. Behavior Analyst (BA) and Behavior Analyst Assistant (BAA):

- a. Board Certified Behavior Analyst-D (BCBA-D)
- b. Board Certified Behavior Analyst (BCBA)
- c. BACB recognized qualifying Psychologist
- d. Mentored Behavior Analyst
- e. Board Certified assistant Behavior Analyst (BCaBA)

2. Behavior Technician (BT):

- a. Registered Behavior Technician (RBT)
- b. Board Certified Autism Technician (BCAT)
- c. Non-certified Behavior Technician

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

4. Non-certified Behavior Technician, Registered Behavior Technician (RBT), or Board-Certified Autism Technician (BCAT)

3.12 Behavior Identification Assessment (97151) Stage 2 Service

If the AEP diagnoses the recipient with ASD and recommends ABA services as part of the recipient's ISP (T1026 TG/HL), the BA/Mentored BA conducts 97151, and as necessary the 97152 or the 0362T ABA Stage 2 Behavior or Functional Analytic Assessments. Utilizing the results of 97151, an ABA Treatment Plan is completed. It is the BA's/Mentored BA's responsibility to provide information which fully describes the current presentation of the recipient and all adjunct practitioners whose input is necessary to fully complete 97151 and an ABA Treatment Plan. The ABA Treatment Plan prioritizes goals for the recipient to ensure the health and safety of the recipient and their family. Unless otherwise noted, the use of 97151 is inclusive of the 97152 or 0362T.

3.12.1 Impact of Adult and EPSDT Grace Exceptions

The recipient, parent or guardian provides the AP agency the recipient's ASD diagnosis rendered by one of the approved Adult and EPSDT Grace Exceptions practitioners. The AP agency begins ABA Stage 2 services. These services continue until CDE (T1026 TG) or Targeted/Risk evaluation (T1026 HK) is completed. See 1.3B(2)(c).

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

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

3.13 Behavior Identification Assessment (97151), Behavior Identification Supporting Assessment (97152) or Behavior Identification Supporting Assessment QHP onsite (0362T) Requirements

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

3.13.1 Direct observation and measurement of behavior

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

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

3.13.1 (B) Interviews with the recipient, members of the Family Set, and other professionals: Members of the Family Set and other stakeholders are included when selecting treatment goals, protocols, and evaluating progress. These interviews, rating scales, and social validity measures should be used to assess the legal guardian and caregiver's perceptions of the recipient's skill deficits and behavioral excesses, and the extent to

which these deficits and excesses impede the functioning of the recipient and member of their Family Set. The recipient should also participate in these processes as developmentally appropriate.

3.14. Selection and Measurement of Goals

Once the information has been gathered and 97151 has been completed, the BA/Mentored BA must select goals for intervention and determine how these goals will be measured. Goal development includes but is not limited to the following components: adaptive and self-care skills, attending and social referencing, cognitive functioning, community participation, coping and tolerance skills, emotional development, family relationships, language and communication, play and leisure skills, pre-academic skills, self-advocacy and independence, self-management, social relationships, and vocational skills. Skills should be addressed using ABA procedures that have been proved effective for developing adaptive behaviors and reducing maladaptive behaviors throughout the lifespan, including but not limited to different types of schedules of reinforcement, differential reinforcement, shaping, chaining, behavioral momentum, prompting and prompt fading, behavioral skills training, extinction, functional communication training, discrete-trial procedures, incidental teaching, self-management, functional assessment, preference assessments, activity schedules, generalization and maintenance procedures, and many others.

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

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

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

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

3.15 Service Model Determination:

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

3.16 Focused ABA:

Focused ABA treatment plans are appropriate for members who (a) need treatment only to develop a limited number of key functional skills or (b) have such risky problem behavior that its treatment should be the priority. Focused ABA generally ranges from 10-25 hours per week of direct treatment (plus direct and indirect supervision and caregiver training). However, certain programs for severe destructive behavior may require more than 25 hours per week of direct therapy (for example, day treatment or inpatient program for severe self-injurious behavior).

3.16.1 Dosage is determined by individualized factors and MAD requires the MCO to adhere to the recommendations from within the individual’s ISP, the Grace Exception Practitioner, and/or Level of ASD diagnosis, as well as the recommendations from the ABA provider based on the individual’s skill deficits as shown in the Stage 2 assessment. Individuals requiring substantial support (Level 2) or very substantial support (Level 3), will likely require a higher dosage of treatment under the selected service model. The BA will develop a discharge plan and update as the individual demonstrates that they have met the discharge goals; however, ABA is a medically necessary treatment and may always be required to maintain an individual’s maximum level of functioning.

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

3.16.1 (B) When the primary focus of treatment is increasing socially appropriate behavior, services may be delivered in either an individual or small-group format. In small-group treatment for patients with developmental disorders, typically developing peers or individuals with similar diagnoses may participate in sessions. Members of the ABA treatment team typically guide patients through the rehearsal and practice of behavioral targets with each other. As is the case for all treatments, programming for generalization of skills outside of formal treatment sessions is critical. Skill acquisition targets in a Focused ABA Treatment Plan include any combination of the goal components identified in 3.3.8.D.

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

3.17 Comprehensive ABA:

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

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

Adult-Recipients: The goal is not necessarily to close the gap between the recipient’s level of functioning and their peers, it is to look at a comprehensive program to:

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

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

3.17.1 (A) Targets are drawn from multiple domains related to cognitive, communicative, social, emotional, and adaptive functioning. Targets also include reducing maladaptive behavior such as aggression, self-injury, disruption, and stereotypy. Given the nature of comprehensive intervention, there must be a Prior Authorization from the EPSDT-aged recipient's MCO or TPA if services are rendered less than 20 hours per week on average. For an adult recipient, Comprehensive Services may range from forty 15-minute units (ten hours) to 160 15-minute units (40 hours).

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

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

3.18 Treatment Settings

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

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

3.18.1 (A) Services provided in a school under an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) do not preclude medically necessary services that are being provided across natural settings, including schools. IEP-related services are still viewed as medically necessary (SLP, OT, PT, SW, etc. administer their own evaluations that determine the need for their services). These services are provided to address a child's disability as it affects them in the educational setting. IEP-related services address specific goals and objective to allow the child to access the educational curriculum and receive a Free and Appropriate Public Education. ABA services are not replacing educational instruction, they are supporting the recipient to participate in their educational services. The NM Public Education Department

has confirmed that ABA services are not considered a related service under the IDEA and therefore schools are not obligated to provide these services. Stage 3 ABA providers should collaborate with the school to identify the best way to incorporate these outside services into the child's education program.

3.18. 1 (B) Recipient may receive ABA Stage 1, 2, and 3 services if they are residing in a variety of living arrangements and regardless of whether they are accessing other MAD medically warranted services. When the recipient is accessing residential living (adult or EPSDT accredited residential center (ARTC), RTC, group), emergency room (ER), hospital inpatient admission or even a dental visit, they are eligible to receive ABA Stage 1-3 services to assist the recipient to fully benefit from these services.

3.19 ABA Treatment Plan

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

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

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

3.19.1 (C) Include a goal of working with the Family Set of the recipient in order to assist with the acquisition, maintenance, and generalization of functional skills;

3.19.1 (D) Incorporate strategies for promoting generalization and maintenance of the goal's behavior change with the recipient's Family Set;

3.19.1 (E) Specify where services are delivered (e.g., home or clinic) in each ABA Stage 3 Service Authorization - initial and ongoing - and in the ABA Treatment Plan; take into account all school or other community resources available to the recipient, and coordinate therapies (e.g., IEP-related services provided in school), with other interventions and treatment (e.g., speech, occupational therapy, physical therapy, individual and family outpatient counseling, and medication management, both physical and behavioral health);

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

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

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

3.19.1 (I) Be specific and individualized to the recipient, with clear identification and description of the target behaviors and symptoms;

3.19.1 (J) Include objective data on the baseline level of each target behavior/symptom in terms of directly observed and measured frequency, rate, latency, or duration, and include scores and interpretation from criterion-referenced, norm-referenced, and/or standardized assessment tools (e.g., The Verbal Behavior Milestones Assessment and Placement Program [VB-MAPP], The Assessment of Basic Language and Learning Skills-Revised [ABLLS-R], Vinland, Adaptive Behavior Assessment [ABAS] and Pervasive Developmental Disorder Behavior Inventory [PDDBI]), as applicable;

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

3.19.1 (L) Establish treatment goals and objective measures of progress on each goal specified to be accomplished in the recipient's Prior Authorized period;

3.19.1 (M) Incorporate strategies for promoting generalization and maintenance of behavior change; and

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

3.20 ABA Stage 2 And 3 Considerations

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

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

1. Behavior and Functional Analytic Assessment describing specific levels of behavior at baseline and informs subsequent establishment of ABA treatment goals;
2. An emphasis on understanding the current and future value (or social importance) of behavior(s) targeted for treatment;
3. A practical focus on establishing small units of behavior which build towards larger, more significant changes in functioning related to improved health and levels of independence;
4. Collection, quantification, and analysis of direct observational data on behavioral targets during treatment and follow-up to maximize and maintain progress toward treatment goals;
5. Efforts to design, establish, and manage the social and learning environment(s) to minimize problem behavior(s) and maximize rate of progress toward all goals;
6. An approach to the treatment of problem behavior that links the function of (or the reason for) the behavior to the programmed intervention strategies;
7. Use of a carefully constructed, individualized and detailed behavior or functional analytic assessment to develop the ABA Treatment Plan that utilizes procedures based on the principles of behavior analysis, including but not limited to different types of schedules of reinforcement, differential reinforcement, shaping, chaining, behavioral momentum, prompting and prompt fading, behavioral skills training, extinction, functional communication training, discrete-trial procedures, incidental teaching, self-management, functional assessment, preference assessments, activity schedules, generalization and maintenance procedures;
8. Use of treatment that is implemented repeatedly, frequently, and consistently across environments until discharge criteria are met;
9. An emphasis on ongoing and frequent direct assessment, analysis, and adjustments to the 97151 and **T1026 UD** Clinical Management, 97155 and 97158) to the ABA Treatment Plan based on the recipient's progress as determined by observations and objective data analysis;
10. An emphasis on ongoing and frequent case supervision of the Mentored BA/BAA/BT rendering ABA Stage 3 services to the recipient;
11. Direct support and training of the recipient's Family Set members, and other involved professionals to promote optimal functioning, generalization and maintenance of behavioral improvements; and

12. A comprehensive infrastructure for clinical management and case supervision of all assessment and treatment by a BA/Mentored BA/BAA/BT.
13. A record must be maintained by the AP agency and, as appropriate, the ABA SCP for each recipient. Records for 0362T and 0373T must be placed in the AP agency's recipient record.
14. All copies of CDE (T1026 TG) or HK, ISP (T1026 TG/HI), ISP update (T1026 HK/HI), and 97151 and ABA Treatment Plans, along with updates to the aforementioned documents, must be maintained as part of the recipient's record by the AP agency.
15. A contact log which documents the delivery of all billable services (including Case Supervision and Clinical Management activities), as well as all clinically significant non-billable services, must be maintained.
16. Each ABA Stage 3 session must be documented by a progress note and as appropriate, graphing. The note must include the date of service, the time and duration of service, location/setting, the practitioner(s) present during the delivery of service, parent or caregiver present, and the clinical content of the session, quantitative data to support the clinical content, and a plan for the next visit. Progress notes must be signed by the practitioner and the supervising BA/Mentored BA/BAA unless the service is rendered by the supervise themselves, in which case only their signature is required. The recipient's Family Set member's signature is not required by MAD.
17. An ABA Treatment Plan Update and Progress Report must be prepared and submitted to the MCO or TPA prior to the end of the recipient's Prior Authorization period and maintained as part of the recipient's record.

| Billing Instructions for 97151 BA and Mentored BA |
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| 97151 BA and Mentored BA |
| <p><u>ABA Stage 2 Behavior or Functional Analytic Assessment</u></p> <p>A Specialty Care Practitioner (SCP) does not bill 97151 or 97152; instead bills 0362T for assessment and 0373T for treatment planning.</p> <p>BA/Mentored BA gathers data, observes and analyzes scores/interprets assessments, and interviews recipient's Family Set which are then incorporated into a Behavior or Functional Analytic Assessment Report and the results are used to develop the ABA Stage 3 Treatment Plan.</p> <p>97151 allows both direct and indirect activities for a BA/Mentored BA.</p> <p>Prior Authorization: NO</p> <p>A BA/Mentored BA must conduct 97151 at least annually or as medically warranted for each recipient without Prior Authorization.</p> <p>Direct 97151 is for the actual assessment is conducted.</p> <p>Indirect 97151 is when scoring and analyzing assessment results, interviewing recipient's Family Set, customizing the completing Behavior or Functional Analytic Assessment Report and the ABA Stage 3 Treatment Plan.</p> <p>Indirect 97151 is billed when the BA/Mentored BA must customize the recipient's environment and materials to conduct 0362T.</p> |

When the BA/Mentored BA directs a BAA to render Indirect 97151, the BAA bills under the BA's/Mentored BA's 1st Modifier when the BAA:

- Interview members of the recipient's Family Set;
- Scores the results of 97151, 97152 and 0362T.

A BA/Mentored BA conducts 97151 at any point during the recipient's Service Authorization without a Prior Authorization when the BA/Mentored BA determines it is medically warranted. The medical necessity must be documented in the recipient's clinical file.

When the BA/Mentored BA reaches out to a SCP to conduct a functional assessment to determine if Specialty Care services are medically warranted, the SCP bills 0362T and 0373T instead of 97151. The medical necessity must be documented in the recipient's clinical file.

A BA/Mentored BA bills Indirect 97151 when conducting interviews or discussing the Treatment Plan or Protocols with the Family Set delivered via telemedicine.

CMS Medicaid NCCI MUE limits:

97151 to eight 15-minute units or 2 hours per day.

Exceeding Medicaid MUE Limits:

Under the following circumstances, a BA/Mentored BA may exceed the CMS Medicaid NCCI MUE limits when billing 97151. Provider must submit clinical rationale for the MUE to be overturned

1. The recipient travels in excess of two hours one-way to complete 97151 by the BA/Mentored BA.
2. The recipient poses a danger to self or others when traveling outside their home to participate in 97151.
3. The scope of the assessment and length of time necessary to conduct the assessment exceeds eight 15-minute units and would necessitate the recipient returning the next day to complete or continue the assessment.
4. The BA/Mentored BA has determined the recipient is able to attend in meaningful ways more than eight 15-minute units of one assessment or multiple assessments that would prevent the recipient and Family Set member from having to return another day to complete the assessment(s).
5. The BA/Mentored BA is completing activities under indirect 97151 for treatment plan development.
 - Bill under the directing BA's/Mentored BA's corresponding 1st modifier.
 - Bill up to eight 15-minute units of 97151 on separate claim lines, not to exceed twenty 15-minute units or five hours for the entire day.

Concurrent Billing:

97152 when rendered by a separate practitioner

In Conjunction with 97151:

97152

0362T

97156 and 97157 while the recipient's initial Behavioral/Functional Analytic Assessment has been scheduled, and when 97151 being conducted
97151 functions

- When the BA/Mentored BA is conducting annual or a medically warranted 97151, all Stage 3 services continue as Prior Authorized.

Do Not Bill:

97151 assessment

0373T

Billing Instructions for 97152

97152 BA, Mentored BA, BAA, RBT/BCAT

ABA Stage 2 – 97152 - Supporting Assessment to 97151

A SCP does not bill 97152; instead bills 0362T.
97151 must be in process to bill 97152.

A BA/Mentored/BA bills 97152. A SCP bills 0362T, as the recipient's presentation requires either practitioner or two or more.

Prior Authorization: NO

The BA/Mentored BA directs the work of one BAA/RBT/BCAT to render supporting assessments for the BA/Mentored BA who completes the Behavior or Functional Analytic Assessment Report. If the BA/Mentored BA determines the need for a supporting assessment requiring two or more BAs/Mentored BAs/BAA/RBTs/BCATs present, see 0362T. The BAA/RBT/BCAT bills under the BA's/Mentored BA's 1st Modifier.

97152 is billed at any point without Prior Authorization during the recipient's Service Authorization when the BA/Mentored BA determines it is medically warranted. The medical necessity must be documented in the recipient's clinical file. A BA/Mentored BA must be conducting 97151 to bill 97152.

Bill 97151 when incorporating the findings of 97152 into the final Behavioral or Functional Analytic Assessment Report by the BA/Mentored BA.

If the Mentored BA/BAA/RBT/BCAT does not have the expertise to render a specialized 97152 assessment, the BA/Mentored BA may bill T1026 UD Case Supervision to provide specific training to the practitioners listed above that are not included in their BACB or BICC certification requirements and are unique to the recipient's 97152. T1026 UD Case Supervision cannot include time spent instructing a Mentored BA/BAA/RBT/BCAT on skills or training related to their BACB or BICC certification. MAD considers these non-reimbursable supervision requirements necessarily to the practitioner gaining and retaining BACB or BICC certification.

CMS Medicaid NCCI MUE limits:

97152 to eight 15-minute units or 2 hours per day.

Exceeding Medicaid MUE Limits:

Under any of the following circumstances, a BA/Mentored BA may exceed the CMS Medicaid NCCI MUE limits of sixteen 15-minute units or 2 hours. The Provider must submit clinical rationale for the MUE to be overturned

1. The recipient travels in excess of two hours one-way to be assessed by the BA/Mentored BA; or
2. The recipient poses a danger to self or others when traveling outside their home or community to participate in the ABA Stage 2 97152 regardless of the travel distance; or
3. The scope of the assessment and length of time necessary to conduct 97152 exceeds eight 15-minute units and would necessitate the recipient returning the next day to complete or continue the assessment.

4. The BA/Mentored BA has determined the recipient is able to attend in meaningful ways more than eight 15-minute units of one assessment or multiple assessments that would prevent the recipient from having to return another day to complete the assessment(s).

Bill 97152 under the directing BA's/Mentored BA's corresponding 1st Modifier.

Bill up to twenty 15-minute units of 97152 on separate claim lines, not to exceed thirty-two 15-minute units or eight hours in total.

Concurrent Billing:

Indirect 97151 when rendered by a separate practitioner.

In Conjunction with 97152:

97151

0362T

97156 and 97157 while the recipient's initial Behavioral/Functional Analytic Assessment has been scheduled and when 97152 is being conducted.

- When the BA/Mentored BA is conducting the annual (not the initial) or medically warranted 97152 during the Service Authorization or during the EPSDT or Adult Grace Period Prior Authorization, all Stage 3 services continue as Prior Authorized.

Do Not Bill:

0373T

Billing Instructions for 0362T

0362T SCP, BA, Mentored BA, BAA, RBT/BCAT

ABA Stage 2 Supporting Assessment to 97151 with 2 or More BAs/BAA's/RBT's/BCAT's

The BA/mentored BA must be in the process of completing 97151 to bill 0362T.

The SCP must be in the process of completing 0373T Specialty Care treatment protocols to bill 0362T.

A BA/Mentored/BA bills 97152 A SCP bills 0362T, as the recipient's presentation requires two or more practitioners.

Maximum number of units per 0362T: twenty 15-minute units with Specialty Care Services up to thirty-two 15-minute units or 8 hours.

The BA/Mentored BA/SCP directs the work of two or more BAs/Mentored/BAs/BAA's/BTs having the expertise to render supporting behavior or functional assessments for the BA/Mentored BA/SCP to complete a Behavior or Functional Analytic Assessment.

0362T may be billed at any point during the recipient's Service Authorization without Prior Authorization when the BA/Mentored BA determines it is medical necessity to complete 97151 or the SCP determines the need for 0362T and 0373T. The medical necessity must be documented in the recipient's clinical file.

Prior Authorization: NO

To bill 0362T the following must all be met:

- 1. Directed by the BA/Mentored BA/SCP who is onsite (meaning immediately available and interruptible).**
- 2. BA/Mentored BA/SCP is closely monitoring two or more BAs/Mentored BAs/BAA/RBT/BCAT implementation of the supporting assessments, providing corrective feedback when needed.**
- 3. The recipient is exhibiting serious dangerous or destructive behavior that requires more than one BA/Mentored BA/BAA/RBT/BCAT be present.**

The BA/Mentored BA configures a safe customized environment to render 0362T based on the recipient's serious dangerous or destructive behaviors. The SCP bills 0373T instead. 0362T cannot be rendered in the recipient's home; must be rendered in a customized center or clinic setting.

Prior to rendering 0362T, the BA/Mentored BA/SCP utilizes 0362T to further explore specific behaviors using two or more BAs/Mentored BAs/BAA/RBT/BCATs to render the supporting functional assessments the BA/Mentored BA/SCP determined is medically warranted in order to develop an ABA Stage 3 Treatment Plan or ABA Specialty Care Treatment Protocols.

Billing 97151, the BA/Mentored BA completes a Risk Assessment (not a *T1026 HK-Risk Evaluation*) to determine the safeguards necessary to conduct a safe functional analysis, then reviews with BAs/Mentored BAs/BAA/RBT/BCATs how to safely implement the supporting assessment in the recipient's customized environment and develops any materials necessary for the supportive assessment. The SCP bills 0373T instead.

Billing 97151, the BA/Mentored BA analyzes, scores, and interprets the results of the findings of 0362T. A SCP bills 0373T instead and if under the direction of the SCP, a BA/Mentored BA may score 0362T billing 0373T under the SCP's 1st Modifier.

If a BA/Mentored BA/BAA/RBT/BCAT does not have the expertise to render 0362T, the BA/Mentored BA bills T1026 UD Case Supervision to provide specific training to the BA/Mentored BA/BAA/RBT/BCAT that is not included in his or he BACB or BICC certification requirements. A SCP bills 0373T under such occurrences.

T1026 UD does not include time spent instructing a BA/Mentored BA/BAA/RBT/BCAT on skills required for their BACB or BICC certification. Such time is not reimbursable by MAD and MAD considers it part of the BACB's or BICC's supervision requirements.

CMS MUE Limits:

CMS Medicaid NCCI MUE limits 0362T to eight 15-minute units or 2 hours per day.

Exceeding Medicaid MUE Limits:

Under any of the following circumstances, a BA/Mentored BA/SCP may exceed the CMS Medicaid NCCI MUE limits of Sixteen 15-minute units or 2 hours. Provider must submit clinical rationale for the MUE to be overturned.

- 1. The recipient travels in excess of two hours one-way to be assessed by the BA/Mentored BA/SCP.**
- 2. The recipient poses a danger to self or others when traveling outside their home or community to participate in the assessment.**

3. The scope of the assessment and length of time necessary to conduct the assessment exceeds eight 15-minute units and would necessitate the recipient returning the next day to complete or continue the assessment.
4. The BA/Mentored BA/SCP has determined the recipient is able to attend in meaningful ways more than eight 15-minute units of one assessment or multiple assessments that would prevent the recipient from having to return another day to complete the assessment(s).

Bill 0362T under the directing BA's/Mentored BA's/SCP's corresponding 1st modifier.

Bill up to eight 15-minute units of 0362T on separate claim lines, not to exceed thirty-two 15-minute units or eight hours in total.

Concurrent Billing:

NONE

In Conjunction with 0362T:

97151 except SCP

97152 except SCP

97156 and 97157 while the recipient's initial Behavioral/Functional Analytic Assessment has been scheduled and when 0362T is being conducted.

T1026 Indirect UD Case Supervision except SCP

0373T -only SCP

- When the BA/Mentored BA is conducting the annual (not initial) or medically warranted 0362T, the recipient continues all Stage 3 services as Prior Authorized.

3.21 ABA Clinical Management and Case Supervision

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

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

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

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

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

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

3.21.1 (D) BACB and BICC Supervision Requirements

- The practitioner’s certifying board has its own supervision requirements for the practitioner to maintain their certification. This type of supervision not reimbursable by MAD. See each practice boards requirements as to whom may render its supervision.

| Billing Instructions for ABA Stage 3 Clinical Management and Indirect/Direct Case Supervision | |
|--|---|
| T1026 UD | BA, Mentored BA, Supervising BAA |
| <p><u>ABA Clinical Management</u></p> <p>T1026 UD Case Management is billed in one-hour units. Please see page 11 and 12 for billing guidance.</p> <p>Prior Authorization: NO As T1026 UD Direct and Indirect Case Supervision and Clinical Management are required in specific amounts, no Prior Authorization is required. If medically warranted, additional units may be requested.</p> <p>T1026 UD Clinical Management is reimbursed for the BA/Mentored BA/Supervising BAA (is a BAA approved by their BA) when making modifications to the treatment plan or protocols.</p> <p>If a Mentored BA/BAA/BT requires additional training to render unique aspects of a specific recipient’s ABA Stage 2 or 3 services, see Indirect T1026 UD Case Supervision.</p> <p>Indirect T1026 UD Case Supervision may be billed to develop the required knowledge and skills to implement the recipient’s Treatment Plan or Treatment Protocol. However, Indirect T1026 UD Case Supervision cannot be billed for the practitioner’s general continuing education to remediate knowledge, skill deficits or build competencies associated with ABA practitioner’s requirements.</p> <p>T1026 UD Clinical Management is rendered at the rate of at least one to two 15-minute units for every eighty 15-minute units or 20 hours of Stage 3 services (except for 97155) and is billed by BA/Mentored BA/Supervising BAA (if approved by their BA) with the BAA/BT not present. The Mentored BA’s/BAA’s Supervising BA provides oversight and review of T1026 Clinical Management to recipients under the BA/Mentored BA/Supervising BAA responsibility. Clinical Management are those activities related to review and analysis of collected data, modification of ABA Treatment Plan and Treatment Protocols, follow-up interviews with the recipient’s Family Set and other agencies involved with the recipient.</p> <p><u>Store and Forward Telemedicine Technology for 97155 :</u></p> | |

To increase rural and frontier ABA Stage 3 services, MAD allows Store-and-Forward telemedicine technology transmissions for ABA Stage 3 97155. Store-and-Forward telemedicine does not occur in real time (asynchronous) and does not require a F2F live encounter with the eligible recipient and the Mentored BA/Mentored BA/BAA/RBT/BCAT and the BA/Mentored BA/Supervising BAA. This technology allows through the transference of digital images, sounds, or previously recorded video sent from the onsite practitioner to the BA/Mentored BA/Supervising BAA to obtain information, analyze it, and report back to the onsite practitioner during their T1026 UD Case Supervision.

MAD allows an AP agency to utilize Store-and-Forward telemedicine technology to provide 100% of Direct 97155 to be rendered when the following requirements are met:

1. An AP agency must submit on an annual basis to the MCO or TPA documentation from the AP agency's telemedicine transmission provider cannot provide real-time telemedicine transmissions between the recipient's location and the BA's/Mentored BA's/Supervising BAA's location. This must also be documented in the recipient's clinical file.
2. 97155 must be increased at least by two 15-minute units or 30 minutes and up to four 15-minute units or 1 hour in addition to the required minimum two 15-minute units or 30 minutes. This would allow the BA/Mentored BA/Supervising BAA to have additional time to discuss and plan with the BAA/RBT/BCAT the implementation of the ABA Treatment Plan and Treatment Protocols.
3. The BA/Mentored BA/Supervising BAA must document in the recipient's file that the use to 97155 delivered through Store-and-Forward telemedicine technology meets the needs of the family, recipient and BAA's/RBT's/BCAT's personnel file substantiates the he or she has the expertise to receive 100% 97155 delivered through Store-and-Forward telemedicine technology, and without the use of Store-and-Forward telemedicine technology the recipient could not access ABA Stage 3 services.
4. A non-certified BT cannot receive 97155f delivered through Store-and-Forward telemedicine technology.

In Conjunction with T1026 UD:

97153

97154

97155 BA/Mentored BA/Supervising BAA (without telemedicine)

97156 rendered by a BA to a Mentored BA/BAA

97157 rendered by a BA to a Mentored BA

97158 rendered by a BA to a Mentored BA

Do Not Bill:

0373T

ABA STAGE 3 IMPLEMENTATION

3.22 Stage 3 Authorizations:

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

adaptive behaviors. Once the Service Authorization is approved, the MCO or TPA reviews the Prior Authorization request.

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

3.23 Prior Authorization Period:

- For a recipient between 12 months to eight years, the Prior Authorizations are every six months during the Service Authorization period.
- For a recipient eight years and older, the Prior Authorizations are six months during the Service Authorization period.
- At any time during the Service Authorization period the recipient, appropriate member of the Family Set or BA/Mentored BA may request from the recipient's AEP conduct T0126 TG, ISP (T1026 TG/HI), Targeted/Risk evaluation (T1026 HK), or HK/HI or the BA/Mentored BA may conduct 97151 if immediate changes are warranted to preserve the health of the recipient or to meet the current needs of the recipient.

3.24 Prior Authorization Requirements

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

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

For concurrent Prior Authorization requests, a discussion of progress made towards the eligible recipient's discharge criteria stated in their Service Authorization; and documentation that demonstrates progress toward goal acquisition or barriers currently presented by the recipient.

3.25 Continuation of ABA Stage 3 Services

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

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

3.26 Termination of or Halt in ABA Stage 3 Services

The eligible recipient's AEP or the Grace Period Exception Practitioners findings and recommendation for Stage 2 and 3 services are approved until such time as the eligible recipient's AEP or BA recommends, transition, termination of or temporary halt of ABA services. Continuation of services should be maintained with the diagnosis of ASD. Services should not be denied based on the recipient demonstrating progress on individual component skills that are the building blocks for the recipient to develop, maintain and/or restore functioning to the maximum extent practical. **Services may be necessary (a) to prevent further advancement of a condition (maintenance or control); (b) ameliorative; or (c) corrective, as when services help a child reach the age-appropriate developmental level.**

1. The recipient requires a higher level of care of which ABA services are temporarily halted until the eligible recipient's presentation supports continuing ABA services by a team of their service providers, legal guardian of the eligible recipient, or as appropriate, the eligible recipient themselves.
2. If the recipient is not responding positively to ABA Stage 3 services for reason(s), including but not limited to, inadequate family participation, insufficient service intensity, or issues with the goals and/or associated interventions outlined in the ABA Treatment Plan, the BA may work with the Managed Care Organization Care Coordinator to address identified barriers of the member. If the recipient is not a MCO member, the BA will be the lead.
 - a. Prior to termination or recommendation to halt in services, AP agency must first make every attempt internally to identify and address the lack of response. However, if the coordinated efforts of the AP agency and MCO Care Coordinator do not result in positive behavior change, the BA may request the recipient's AEP:
 - i. Complete a new CDE and ISP;
 - ii. Complete a Targeted Evaluation and new ISP (when a new full CDE is not required);
 - iii. Complete a new Risk Evaluation and new Risk Report for recipients under three years of age;
 - iv. Complete an updated ISP.
 - b. The BA may refer the recipient to a SCP for increased clinical support.
 - c. The BA will provide alternative opportunities for Family Set members are not able to attend ABA Stage 3 CPT 97156 or 97157 sessions at the agreed level.
2. If the barriers are temporary or for a short duration (one month), the BA and recipient or Family Set may agree to halt services and restart at the predetermined date.
3. If the barriers cannot be overcome within one month, the AP agency may terminate ABA Stage 3 services to the recipient to allow time for barriers to be resolved.
 - a. Unless medically warranted for immediate discharge, discharge date must be at least 30 calendar days from the date the recipient or Family Set is notified in writing.
 - b. Once the recipient or Family Set agrees to restart services, the BA will complete ABA Stage 2 services and submit a new 6-month prior authorization.
 - c. If the length of time the recipient was not receiving services is past the recipient's last Service Authorization period, a new Service Authorization is to be submitted with the new prior authorization.
 - d. The AP agency is not obligated to accept the recipient back after they were terminated; instead the AP agency may refer the recipient to another AP agency.

Billing Instructions for ABA Stage 3

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

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

TIER ONE – Adult ABA Tier One Criteria – Maintenance

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

TIER TWO – Adult ABA Tier Two Criteria – Intervention Services

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

- Illness of self or caregiver resulting in the eligible recipient's adaptive coping responses becoming maladaptive;
- Multiple service settings and multiple staff or caregivers, such as an eligible recipient who is residing in a residential setting, has day habilitation, and interactions with parents.
- Movement from current living situation to a new living situation, thus disrupting their patterns of daily resulting in the eligible recipient's adaptive coping responses becoming maladaptive:
- Addition of new services that introduce new expectations or new staff that disrupt their patterns of daily living resulting in the eligible recipient's adaptive coping responses becoming maladaptive.

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

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

For adult recipients experiencing destructive or self-injurious behavior, or behavior injurious to others, resulting in the eligible recipient's adaptive coping responses becoming maladaptive such as the eligible

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

97155 BA, Mentored BA, Supervising BAA

ABA Stage 3 Adaptive Behavior Treatment by Protocol Modification –

97155 is designed to evaluate the effectiveness of the treatment plan and recipient's response to treatment. 97155 is utilized when the BA/Mentored BA/Supervising BAA is rendering the service either present with the recipient and Mentored BA/BAA or BT or delivered through telemedicine where the BA/Mentored BA/Supervising BAA solves at least one problem and may, at the same time direct the Mentored BA/BAA/BT and a member of the Family Set in how to implement the new or revised Treatment Protocols. The recipient must be present during the session, including the time instructions are provided to the Mentored BA/BAA/BT and Family Set.

Bill in 15-minute units.

Prior Auth: No

As 97155 is required in specific amounts, no prior authorization is required. If medically warranted, additional units may be requested.

For an adult recipient accessing Adult ABA, for the first 6 or eight weeks of services, the recipient may receive units in excess of those listed below.

At least four 15-minute units or one hour of 97155 must be rendered for every eighty 15-minute units or 20 hours of combined 97153, 97154 and 97156 including those codes authorized to be rendered by a Mentored BA/Supervising BAA.

1. BA/Mentored BA/Supervising BAA directs treatment with the recipient and Mentored BA/BAA/BT by observing changes in the recipient's behavior or troubleshooting Treatment Protocols. Under this situation 97155 may be delivered through telemedicine.
2. BA/Mentored BA/Supervising BAA joins in person the recipient to direct the Mentored BAA's/BAA's/BT's implementation of a new or modified Treatment Protocol. Under this situation, 97155 may not be delivered through telemedicine as the recipient and BA/Mentored BA/Supervising BAA are in the same location.

CMS Medicaid NCCI MUE limits:

97155 up to twenty-four 15-minute units or 6 hours per day.

An adult recipient accessing Adult ABA services may receive additional 97155 services as medically warranted and documented in the recipient's clinical record. If the units exceed twenty-four 15-minute units, bill no more than this amount per claim line.

1. Prior to rendering 97155, the BA/Mentored BA may bill T1026 UD Clinical Management for the BA/Mentored BA to review the current treatment targets, recipient's responses to changes in routines or Treatment Protocols and responses to the unavailability of preferred items in the recipient's Treatment Protocols.

After 97155, the BA/Mentored BA may bill T1026 UD Clinical Management to analyze the graphed data collection and results, and if needed, modify the individual or group Treatment Protocols or ABA Stage 3 Treatment Plan. The BA/Mentored BA/Supervising BAA may bill Indirect T1026 UD Case Management to discuss changes with the Mentored BA/BAA/BT.

Concurrent Billing of 97155:

97153

97154

97156 if BA is providing supervision to a Mentored BA

97157 if BA is providing supervision to a Mentored BA

97158 if BA is providing supervision to a Mentored BA

In Conjunction with 97155:

T1026 UD Clinical Management

- When the BA/Mentored BA is conducting an annual or medically warranted 97151, 97152, 0362T or a SCP is conducting 0362 to determine if 0373T is medically warranted, and the recipient is receiving Stage 3 services, the BA/Mentored BA/Supervising BAA may continue 97155 as approved.

Do Not Bill:

D

97155 if the BA/Mentored BA/Supervising BAA is directly rendering the service

97156 BA, Mentored BA, Supervising BAA

ABA Stage 3 –Family Adaptive Behavior Treatment Guidance with or without the Recipient Present – One Family Set

The BA/Mentored BA/Supervising BAA helps the members of the Family Set learn how to identify behavioral problems and how to implement treatment strategies to minimize the recipient's destructive behavioral concerns.

Bill in 15-minute units.

Maximum number of units per 97156 for entire Family Set: thirty-two 15-minute units per week.

Prior Auth: No

It is MAD's intention to support a member of the recipient's Family Set to take advantage of any opportunity to enhance their engagement in the recipient's ABA Stage 3 services. Recipients may or may not be present for 97156. A recipient's Family Set may access 97156 after the recipient's Behavioral/Functional Analytic Assessment is scheduled and the assessment is being conducted.

Any member of the Family Set is approved to participate in 97156 with or without the recipient present.

A Family Set is inclusive of the recipient's family members, caregivers or other support individuals. Bill for the entire Family Set as one 97156, do not bill each individual member of the Family Set separately.

CMS Medicaid NCCI MUE limits:

97156 to sixteen 15-minute units or six hours per day.

For an adult recipient accessing Adult ABA services, they receive additional 97156 services as medically warranted up to thirty-two 15-minute units and documented in the recipient's clinical record. If the units exceed sixteen 15-minute units, bill no more than this amount per claim line. Provider must submit clinical rationale for the MUE to be overturned.

Prior to rendering 97156, the BA/Mentored BA/Supervising BAA may bill 97155 for the BA/Mentored BA/Supervising BAA and the BAA/BT to review how the members of the Family Set are implementing ABA Stage 3 services to develop individualized guidance when rendering 97156.

After 97156, the BA/Mentored BA/Supervising BAA bills T1026 UD Clinical Management to analyze the interactions and concerns raised by the Family Set, and if needed, modify the recipient's Treatment Protocols or ABA Stage 3 Treatment Plan to address these concerns brought up during the 97156 session with the Family Set. The BA/Mentored BA/Supervising BAA bills Indirect T1026 UD to discuss with the Mentored BA/BAA/BT.

After 97156, the BA/Mentored BA/Supervising BAA may bill T1026 UD Case Supervision to analyze the graphed data collection and results, and if needed, modify the individual or group Treatment Protocols or ABA Stage 3 Treatment Plan. The BA/Mentored BA/Supervising BAA bills Indirect T1026 UD Case Supervision to discuss changes with the Mentored BA/BAA/BT.

Concurrent Billing:

97155

- A BAA/BT may render 97153 or 97154 and bill for these codes when the recipient is not present with the Family Set and the BAA is not rendering 97156 as these are two distinct services.

In Conjunction with 97156:

97153

97154

97155

97157

97158

Indirect T1026 UD Case Supervision and Clinical Management

- When the BA /Mentoring BA is conducting the annual or additional 97151, 97152, 0362T or a SCP is conducting 0362T to determine if 0373T is medically warranted, a recipient may continue 97156.

Do Not Bill:

97155 if the BA/Mentored BA/Supervising BAA is directly rendering the service

97157 Qualifying Psychologist, BCBA-D, BCBA, Mentored BA

ABA Stage 3 – Multi-Family Group Adaptive Behavior Treatment Guidance – Without Recipients

Bill in 15-minute units.

The BA/Mentored BA helps the members of the multiple Family Sets learn how to identify behavioral problems and how to implement treatment strategies to minimize the recipient's destructive behavioral concerns.

Prior Auth: No

It is MAD's intention to support a member of the recipient's Family Set to take advantage of any opportunity to enhance their engagement in the recipient's ABA Stage 3 services. No recipients are present for 97157. A recipient's Family Set may access 97157 after the recipient's Behavioral/Functional Analytic Assessment is scheduled and when the assessment is being conducted.

- Any member of the Family Set is approved to participate in 97157 while the recipient is receiving 97153, 97154 and 97158.
- A member of the Family Set is approved to participate in any session of 97157 when approved by the recipient's BA/Mentored BA.

CMS Medicaid NCCI MUE limits:

97157 up to sixteen 15-minute units or four hours per day.

1. For an adult recipient accessing Adult ABA services, they receive additional 97157 services up to thirty-two 15-minute units as medically warranted and documented in the recipient's clinical record. If the units exceed sixteen 15-minute units, bill no more than this amount per claim line.

Prior to rendering 97157, the BA/Mentored BA may bill 97155 for the BA/Mentored BA and the Mentored BA/BAA/BT to review any changes based on the results of the BA's/Mentored BA's T1026 UD Case Supervision when there is a modification in recipient's Treatment Protocol or ABA Stage 3 Treatment Plan.

After 97157, the BA/Mentored BA may bill Indirect T1026 UD Clinical Management to analyze the interactions and concerns raised by the Family Set, and if needed, modify the recipient's Treatment Protocols or ABA Stage 3 Treatment Plan to address these concerns brought up during the 97157 session with the Family Set. The BA/Mentored BA bills T1026 UD Case Supervision to discuss with the Mentored BA/BAA/BT.

Concurrent Billing:

97155

In Conjunction with 97157:

97153

97154

97156

97158

Indirect T1026 UD Case Supervision and Clinical Management

- When the BA/Mentored BA is conducting the annual or medially warranted 97151, 97152, 0362T or a SCP is conducting 0362T to determine if 0373T is medically warranted, recipient may continue 97157 as approved.

- A BAA/BT may render and bill 97153 or 97154 to a recipient who is not present with the Family Set as these are two distinct services.

Do Not Bill:

97155 if the BA/Mentored BA is directly rendering the service

97158 BA, Mentored BA

ABA Stage 3 Treatment Protocol Modification – Recipient Group

The BA/Mentored BA assists recipients to improve their social skills through practice, corrective feedback, and homework assignments, focusing on each recipient’s individual social and behavior issues. The BA/Mentored BA oversees and is responsive to each recipient’s needs and makes appropriate adjustments for the individual recipients and the group as necessary in real time. A group is constructed of two to six recipients and may include Medicaid and non-Medicaid recipients.

Bill in 15-minute units.

Prior Auth: No

1. For a recipient 12 months up to eight years, six-month Prior Authorizations are required and may be submitted at any point during the 36-month service Authorization.
2. For a recipient eight years and older, 12-month Prior Authorizations are required and may be submitted at any point during the six-year Service Authorization.
3. For an adult recipient accessing Adult ABA no Prior Authorization is required for the first 6 or eight weeks of services. Thereafter, Prior Authorization is required.

If BA/Mentored BA determines it is medically warranted to increase units, submit a new Prior Authorization to increase 97158 units.

97153, 97154 and 97158 - for an adult recipient accessing Adult ABA

CMS Medicaid NCCI MUE limits:

- 97158 to sixteen 15-minute units or four hours per day.
- For an adult recipient accessing Adult ABA, they receive additional 97158 services up to twenty-four 15-minute units as medically warranted and documented in the recipient’s clinical record. If the units exceed sixteen 15-minute units, bill no more than this amount per claim line.

The differences between 97154 and 97158 are:

1. 97154 may be rendered by a BA/Mentored BA/BAA/BT and the focus is the recipient’s treatment protocols delivered in a group setting and there is no modification to Treatment Protocols. 97158 is rendered only by a BA/Mentored BA.
2. 97158 includes modification to a recipient’s Treatment Protocols during the group session.

Prior to rendering 97158, the BA/Mentored BA may bill 97155 for the BA/Mentored BA and the Mentored BA/BAA/BT to review any changes based on the results of the BA’s/Mentored BA’s Indirect T1026 UD Clinical Management when there is a modification in recipient’s Treatment Protocol or ABA Stage 3 Treatment Plan.

After 97158, the BA/Mentored BA may bill Indirect T1026 UD Clinical Management to analyze the interactions and concerns raised during the session, and if needed, modify the recipient's Treatment Protocols or ABA Stage 3 Treatment Plan to address these concerns brought up during the 97158 session. The BA/Mentored BA may bill T1026 UD Case Supervision to discuss with the Mentored BA/BAA/BT.

Concurrent Billing:

97155

In Conjunction with 97158:

97153

97154

97156

97157

Indirect T1026 UD Case Supervision and Clinical Management

- When the BA/Mentored B is conducting the annual or medically warranted 97151, 97152, 0362T or a SCP is conducting 0362T to determine if 0373T is medically warranted, recipient may continue 97158 as approved.

Do Not Bill:

97155 if the BA/Mentored BA is directly rendering the service.

STAGE 3 ABA SPECIALTY CARE

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

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

Option 1 Coursework and Experiential Training

ABA Specialty care practitioner graduate coursework and experiential training:

- a. The SCP applicant must hold documentation of graduate level coursework specific to the assessment and treatment of an ASD referral concern associated with an ABA Specialty Care Area. The graduate level coursework must be the equivalent of at least one 3-credit hour course i.e., 45 classroom contact hours and 45 non-classroom contact hours, specific to the ABA Specialty Care Area they intend to address with a recipient. In other words, a SCP can only render ABA Specialty Care services for the ABA Specialty Care Area for which they have met the advanced training and experience requirements; and
- b. Complete 500 hours in the specific ABA Specialty Care Area under supervision from a BCBA, BCBA-D, a Qualifying Psychologist, or other credentialed practitioner who has 3 or more years of documented

experience in the specific ABA Specialty Care Area. The 500 hours must be in a specific ABA Specialty Care Area implementing treatment protocols by either working directly with a recipient or directing a BA/Mentored BA/Supervising BAA/RBT/BCAT working with a recipient with at least 125 delivery hours acquired post master's degree. Not more than 350 delivery hours may be counted from meeting their BCBA, BCBA-D, or Qualifying Psychologist certification requirements, implementing the specific ABA Specialty Care treatment protocols with working directly with a recipient or directing a BAA or BT working with a recipient. The 500 hours must include 25 hours of directly supervised case management in the ABA Specialty Care Area.

Option 2 Experiential Training Only:

The SCP applicant must complete:

- a. 1,000 hours in the specific ABA Specialty Care Area under supervision by a BCBA, BCBA-D, Qualifying Psychologist, or other credentialed practitioner who has three or more years of documented experience in the ABA Specialty Care Area. A Mentored BA is not approved.
- b. The 1,000 hours must be in a specific ABA Specialty Care Area implementing treatment protocols by either working directly with a recipient or directing a BA/Mentored BA/BAA/RBT/BCAT working with a recipient with at least 250 delivery hours acquired post master's degree.
- c. Not more than 712.5 delivery hours may be counted from meeting their BCBA, BCBA/D or Qualifying Psychologist certification requirements, implementing the specific ABA Specialty Care Area treatment protocols by working directly with a recipient or directing a BA/Mentored BA/BAA/RBT/BCAT working with a recipient.
- d. The 1,000 hours must include 37.5 hours of directly supervised case management in the ABA Specialty Care Area.

3.6.2 B Prior Authorization of ABA Specialty Care Services:

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

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

3.6.3 C Process:

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

3.6.4 .D ABA Specialty Care Areas

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

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

Billing Instructions for ABA Specialty Care

0373T Specialty Care Practitioner (SCP)

ABA Stage 3 Specialty Care - Adaptive Behavior Treatment with Protocol Modification

The SCP directing two or more BAs/Mentored BAs/BAAAs/RBTs/BCATs (practitioners) who provoke responses from various but specific environmental circumstances in response to which the recipient may experience or has experienced dangerous or destructive behaviors. The SCP studies the recipient's responses and makes modifications until the ABA Specialty Care Area Treatment Protocol goals have been met. 0373T allows the practitioner to serve as a proxy by capturing the data the SCP has directed of them.

Bill in 15-minute units.

Prior Authorization: Yes

The SCP must submit the Specialty Care Treatment Protocols, and all other documentation required by the MCO or TPA.

CMS Medicaid NCCI MUE limits:

0373T to twenty 15-minute units or five hours

0373T Requirements:

1. SCP must be onsite with the recipient, meaning immediately available and interruptible to assist and provide direction throughout the performance of the procedure; however, the SCP does not need to be present in the same room when the procedure is performed; and
2. Two or more practitioners are present with recipient; and

3. SCP completes and bills 0362T for the functional assessment and bills 0373T for the report/treatment plan/protocols.
4. Recipient must be exhibiting one or more of the Specialty Care Areas; and
5. The SCP must complete a Risk Assessment billing 0373T to determine if the practitioner or the recipient will wear protective equipment for the safety of each and then design the recipient's customized environment where they are located based on the recipient's behavior for 0362T and 0373T.

The SCP bills 0373T to:

- Conduct a Risk Assessment.
- Customize the environment and materials the recipient will be assessed in and where 0362 and 0373T will be delivered for each session.
- Provide specialized instructions unique to the recipient to the practitioners will be assisting the SCP render 0373T.
- Score and analyze results of 0362T.
- Interview Family Set members and other providers engaged with recipient, and if applicable, the recipient.
- Design and oversee 0373T Treatment Protocols implementation.
- Renders 0373T Treatment Protocols directly with two or more practitioners present.
- If approved by the SCP, a BA/Mentored BA/BAA/RBT/BCAT bills for these services under the SCP's 1st Modifier.

As 0373T requires at least two practitioners in addition to the SCP, only one practitioner bills 0373T using the SCP's first modifier at any time regardless of the number of practitioners that are present.

If the practitioner does not have the expertise to render 0373T, the SCP bills 0373T to provide specific training to the recipient that are not included in their BACB or BICC certification requirements and are unique to the recipient. 0373T cannot include time spent instructing a practitioner on skills or training related to their BACB or BICC certification. MAD considers these non-reimbursable supervision requirements necessarily to the practitioner gaining and retaining BACB or BICC certification.

For clinical management and case supervision and other activities traditionally billed under Direct and Indirect T1026 UD, for Specialty Care Services bill those activities under 0373T.

Concurrent Billing:

When the SCP directly renders some of the Specialty Care Treatment Protocols, the SCP bills 0373T in addition to the other practitioner billing 0373T. In this situation, bill the other practitioner's time on one claim line utilizing the SCP's 1st Modifier, and the SCP's time on separate claim line.

In Conjunction with 0373T:

0362T

- If the SCP agrees, 97153, 97154, 97155, 97156, 97157, 97158 may be billed by the approved practitioners for these services. SCP approval to continue approved Stage 3 services must be documented in the recipient's clinical file.

Do Not Bill:

97151

97152

T1026 Indirect and Direct UD

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

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

ABA Stage 1-3 Non-Covered Services

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

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

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

Links

Treatment of Autism Spectrum Disorders must be consistent with generally accepted standards of care. The framework for medical necessity decisions using nationally recognized standards of care include the following eight principles of accepted standards of care:

1. Effective treatment requires treatment of the individual's underlying condition and is not limited to alleviation of the individual's current symptoms.
2. Effective treatment requires treatment of co-occurring mental health and substance use disorders and/or medical conditions in a coordinated manner that considers the interactions of the disorders when determining the appropriate level of care.
3. Patients should receive treatment for mental health and substance use disorders at the least intensive and restrictive level of care that is safe and effective.
4. When there is ambiguity as to the appropriate level of care, the practitioner should err on the side of caution by placing the patient in a higher level of care.
5. Effective treatment of mental health and substance use disorders includes services needed to maintain functioning or prevent deterioration.
6. The appropriate duration of treatment for mental health and substance use disorders is based on the individual needs of the patient; there is no specific limit on the duration of such treatment.
7. The unique needs of children and adolescents must be taken into account when making decisions regarding the level of care involving their treatment for mental health or substance use disorders.
8. The determination of the appropriate level of care for patients with mental health and/or substance use disorders should be made on the basis of a multidimensional assessment that takes into account a wide variety of information about the patient.

Generally accepted standards of care are those standards which are based on credible scientific evidence and generally recognized by behavioral health experts. Sources of generally accepted standards of care based on professional society guidelines include, but are not limited to:

1. Applied Behavior Analysis (ABA) Coding Coalition (2020). Model Coverage Policy for Adaptive Behavior Services. https://cdn.ymaws.com/www.apbahome.net/resource/collection/1FDDBDD2-5CAF-4B2A-AB3F-DAE5E72111BF/ABA_Coding_Coalition_Model-Coverage-Policy_Sept2020_copy.pdf
2. Behavior Analyst Certification Board & Association for Professional Behavior Analysts. (2019). Clarifications Regarding Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers (v.2). <https://cdn.ymaws.com/www.apbahome.net/resource/collection/1FDDBDD2-5CAF-4B2A-AB3F-DAE5E72111BF/Clarifications.ASDPracticeGuidelines.pdf>
3. Council for Autism Service Providers (CASP) (2014). Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers. <https://casproviders.org/wp-content/uploads/2020/03/ABA-ASD-Practice-Guidelines.pdf>
4. Council for Autism Service Providers (CASP) (2020). Organizational Guidelines: Telehealth. https://cdn.ymaws.com/www.apbahome.net/resource/collection/1FDDBDD2-5CAF-4B2A-AB3F-DAE5E72111BF/CASP_Telehealth_&_Crisis_Management_Guidelines.pdf
5. Council for Autism Service Providers (CASP) (2020). Practice Parameters for Telehealth-Implementation of Applied Behavior Analysis: Continuity of Care during the COVID-19 Pandemic. https://casproviders.org/wp-content/uploads/2020/03/PracticeParametersTelehealthABA_040320.pdf

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

Qualifying Psychologist

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

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

Task Lists

1. RBT Task List <https://www.bacb.com/wp-content/uploads/2017/09/161019-RBT-task-list-english.pdf>
2. BCAT Task List <https://www.behavioralcertification.org/Content/Downloads/TASKLIST-BICC-2015.pdf>
3. BCBA and BCaBA <https://www.bacb.com/wp-content/uploads/2017/09/160101-BCBA-BCaBA-task-list-fourth-edition-english.pdf>

Handbooks

1. BCAT https://behavioralcertification.org/wp-content/uploads/2019/12/BCAT_Candidate_Handbook_20191125.pdf

Standards for Supervision

1. BCaBA https://www.bacb.com/wp-content/uploads/2020/05/Standards-for-Supervision-of-BCaBAs_180924.pdf
2. RBT <https://www.bacb.com/rbt/responsible-certificants/>
3. BCAT https://www.behavioralcertification.org/Content/Downloads/BCAT_Supervision_Requirements.p df