Professional Network Reimbursement Policy

Policy Title	**Reimbursement for the Diagnosis and Treatment of Autism Spectrum Disorder**
Policy Number	**NR-30.014**

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I. DESCRIPTION/BACKGROUND

This policy documents the reimbursement methodology and reporting requirements for Applied Behavioral Analysis (ABA) when provided by a Capital BlueCross (CBC) network provider for covered conditions in accordance with Pennsylvania Autism Insurance Act (Act 62).

II. DEFINITIONS

American Medical Association (AMA) **–** An organization whose missions is to promote the science and are of medicine and the betterment of public health. The AMA speaks out on issues important to patient and the nation's health and exercises a strong advocacy agenda on behalf of patients and provider. The AMA is also committed to providing timely information on matters important to the health of America and includes the development and promotion of standards in medical practice, research and education.

Applied Behavioral Analysis (ABA) – The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Autism Spectrum Disorder (ASD) – Any of the Pervasive Developmental Disorders defined by the most recent edition of the Diagnostic and Statistical Manual of

Mental Disorders (DSM), or its successor, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

Centers for Medicare and Medicaid Services (CMS) –The current name of the government agency, which administers Medicare.

Current Procedural Terminology (CPT) – A set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care professionals. Each procedure or service is identified with a five-digit code. The use of CPT codes simplifies the reporting of procedures and services.

Healthcare Common Procedure Coding System (HCPCS) - A national standard, alphanumeric coding system established by the Centers for Medicare and Medicaid Services. It standardizes billing and payment for certain covered services (for example, medical supplies, prosthetics and durable medical equipment). HCPCS Level I codes are copyrighted by the American Medical Association (CPT). Level II codes are five-position alphanumeric codes maintained jointly by the Alpha-Numeric Panel (consisting of the Centers for Medicare and Medicaid Services (CMS), the Health Insurance Association of America, and the BlueCross and BlueShield Association). The American Dental Association copyrights the D-code series in Level II HCPCS.

Modifier – A two-digit numeric, alphanumeric or alphabetic code appended to a CPT or
HCPCS code, which indicates that a service or procedure has been altered by some specific circumstances but not changed in its definition or code. This information is important because it provides payers with additional information to process a claim. There are three levels of modifiers: Level I (CPT) modifiers are developed by the AMA; Level II
(HCPCS) modifiers are developed by CMS; Level III modifiers are unique to each Medicare Part B carrier (local codes) and begin with an alpha prefix of S, W, X, Y or Z.

Pervasive Developmental Disorders (PDD) – Conditions characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests, and activities. The qualitative impairments that define these conditions are distinctly deviant relative to the individual's developmental level or mental age.

III. POLICY

In order to be eligible for reimbursement consideration, providers of Applied Behavioral Analysis (ABA) services are required to report ABA services using the most appropriate American Medical Association (CPT) codes and Level II HCPCS

modifiers from the list below. Providers should report total units (time based) for each service reported.

ABA Codes Eligible for Reimbursement

97151 - Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan

*__Note__: Reimbursement for the services reflected in this code description will not exceed the equivalent of 48 units [12 hours] of service.

97153 - Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes

97154 - Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes

97155 - Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes

97156 - Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes

97157 - Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes

97158 - Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes

0362T - Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; first 30 minutes of technician(s) time, face-to-face with the patient

0373T - Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians' time, face-to-face with patient

Providers are required to report one of the following Level II HCPCS Modifiers with the appropriate Level II Procedure Code (listed above) based on the education level of the provider performing the service. If a procedure code for ABA is submitted without one of these modifiers, the service will be denied as invalid modifier/procedure combination and the provider will be required to resubmit the charge with the appropriate modifier.

HP - Doctoral Level – Board certified behavior analyst or behavior specialist consultant

HO - Masters Level – Board certified behavior analyst, behavior specialist consultant, or mobile therapist

HN - Bachelor's Degree Level – Board certified assistant behavior analyst

HM - Less than bachelor's degree level – non-certified support staff or therapeutic staff support

In addition to the above, providers are reminded that clean claims requirements must be met for prompt adjudication of claims to occur. These include but are not limited to accurate and correct reporting of place of service, billing provider, rendering provider (when appropriate), number of units, and primary diagnosis in the first position. Providers may refer to the current Capital BlueCross Provider Manual for clean claims requirements and claims submission.

Note: CBC utilizes Place of Service Codes as documented and updated from time to time in the CMS Place of Service Code Set available on the CMS website.

Reimbursement consideration for the treatment and diagnosis of ASD will be made at 100% of the Plan allowance, in accordance with all other applicable reimbursement requirements and methodologies as documented in Capital BlueCross Professional Network Reimbursement Policies in effect for the date(s) the service(s) are provided.

In addition to the criteria and conditions contained in this policy, the service, procedure or item must be deemed medically necessary, must be a covered member benefit and is subject to member cost sharing provisions.

Please refer to the following Professional Network Reimbursement Policies for additional information:

NR 30.009 Reimbursement of Mental Health Services

Specific information pertaining to the Pennsylvania Autism Insurance Act (Act 62) can be located by accessing the Pennsylvania Department of Human Services website

Specific information pertaining to the Centers for Medicare and Medicaid Services (CMS) Place of Service codes can be located by accessing the CMS website

2020 Capital BlueCross Provider Manual

American Medical Association

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V. EXCLUSIONS

N/A

VI. VARIATIONS

This policy is applicable to all programs and products administered by Capital BlueCross unless otherwise indicated below.