”Dotting the i’s and crossing the t’s”

What ABA Providers Need to Know about Documentation

February 25, 2021

Autism Insurance Resource Center
UMass Medical School/EK Shriver Center

University of Massachusetts Medical School
umassmed.edu

Documentation Compliance

Dotting the I's and Crossing the T's

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Presented by

The Autism Insurance Resource Center

BABAT

Massachusetts Association for Applied Behavior Analysis – Mass ABA

MASSCAP
MASSACHUSETTS COALITION FOR ABA PROVIDERS

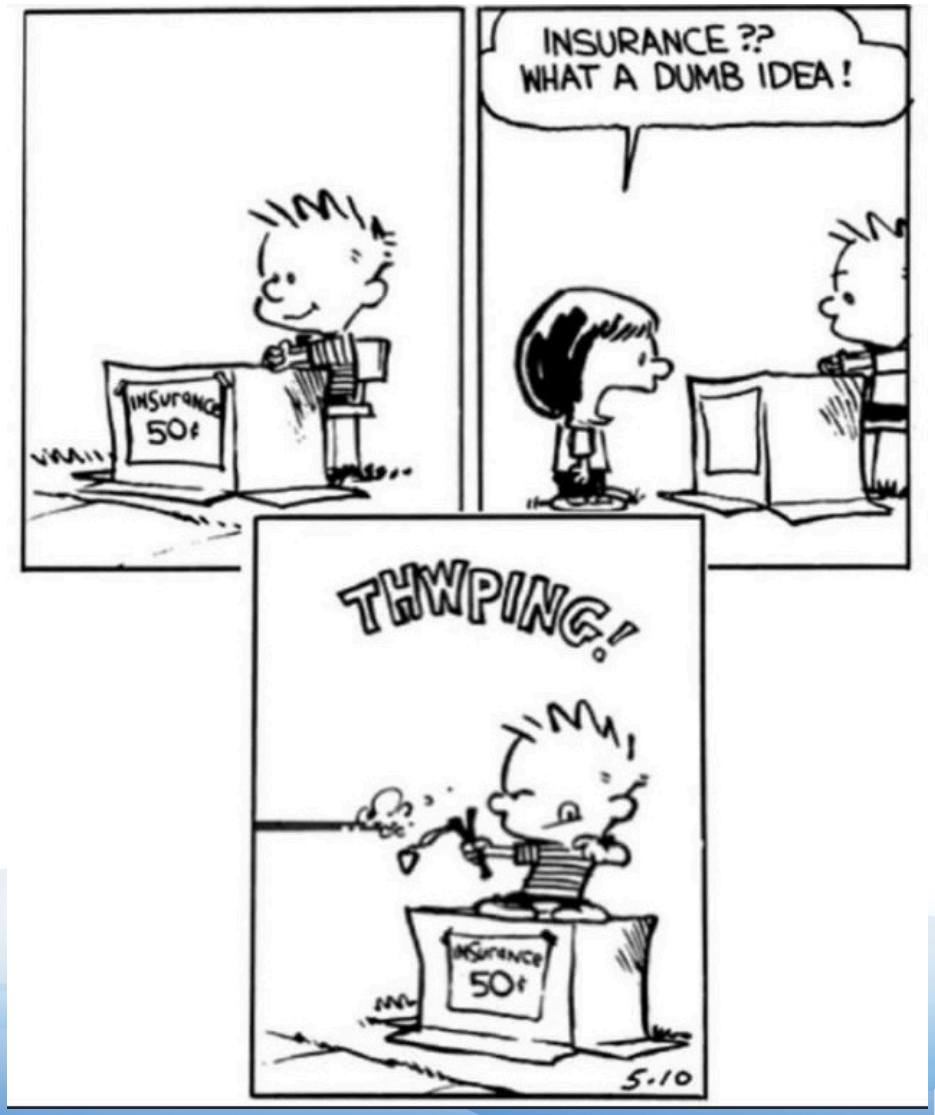
Acknowledgments

AIRC Core Funders

MA Developmental Disabilities Council, Nancy Lurie Marks Family Foundation,Doug Flutie Jr. Foundation for Autism,MA Department of Developmental Services (DDS), Department of Public Health (DPH), Department of Elementary and Secondary Education (DESE), Executive Office of Health and Human Services (EOHHS), UMassMedical School

Special thanks to Susan Ainsleigh, MassABA, and Donna Caira, AIRC

Introduction
Check-In Code - 6708



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Anti-Trust

Be aware of anti-trust laws in your comments & questions

Please refrain from naming individual funders, discussing rates, etc.

Disclosure

- This presentation is not legal advice
- We encourage providers to consult with their agency's attorney for legal counsel

Why is Documentation so Important

- Communication
- Outcomes
- Protection
- Reimbursement contingencies

Laws & Regulations

State

Federal

Create a Compliance Plan or Checklist

- ❑Human Resources
- ❑Medical Necessity
- ❑Clinical Documentation

Human Resources Compliance

- Certification and Licensure
- Training Requirements 
- Background Checks 

- Office of the Inspector General (OIG)

U.S. Department of Health and Human Services
Office of Inspector General

Human Resources Compliance

Topic	Entity	Citation
Basic IEP and special education information	MassHealth	Performance Specs (PS)
behavior management coaching	MassHealth	PS
child/adolescent development including sexuality	MassHealth	PS
community resources and services	MassHealth	PS
conflict resolution	MassHealth	PS
crisis management	MassHealth	PS
ethnic, cultural, and linguistic considerations of the community	MassHealth	PS
family-centered practice	MassHealth	PS
introduction to child-serving systems and processes (DCF, DYS, DMH, DESE, etc.)	MassHealth	PS
managed care entities performance specs and medical necessity criteria	MassHealth	PS
Overview of clinical and psychological needs of target population	MassHealth	PS
psychotropic medications and possible side effects	MassHealth	PS
risk management/safety plans	MassHealth	PS
social skills training	MassHealth	PS
systems of care principles and philosophy	MassHealth	PS

Human Resources Compliance

OIG has the authority to exclude individuals and entities from Federally funded health care programs for a variety of reasons, including a conviction for Medicare or Medicaid fraud. Those that are excluded can receive no payment from Federal healthcare programs for any items or services they furnish, order, or prescribe. This includes those that provide health benefits funded directly or indirectly by the United States (other than the Federal Employees Health Benefits Plan).

The Components of an Effective Compliance Plan

- Health and Human Services Office of the Inspector General

U.S. Department of Health and Human Services
Office of Inspector General

DEPARTMENT OF HEALTH AND HUMAN SERVICES

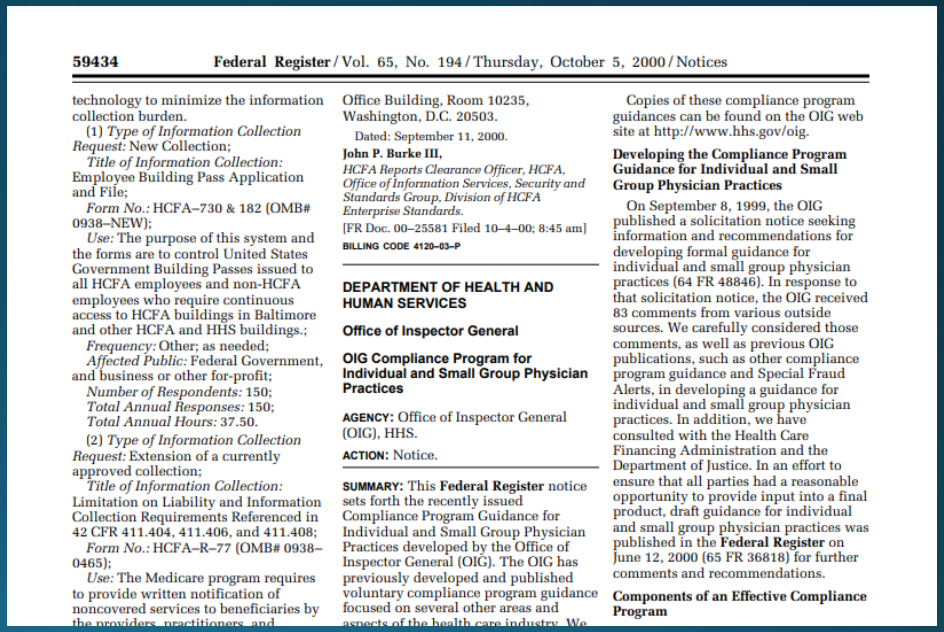
Office of Inspector General

Publication of the OIG Compliance Program Guidance for Home Health Agencies

AGENCY: Office of Inspector General (OIG), HHS.

ACTION: Notice.

SUMMARY: This **Federal Register** notice sets forth the recently issued Compliance Program Guidance for Home Health Agencies developed by the Office of Inspector General (OIG) in cooperation with, and with input from,



59434 **Federal Register** / Vol. 65, No. 194 / Thursday, October 5, 2000 / Notices

technology to minimize the information collection burden.

(1) *Type of Information Collection Request:* New Collection;
Title of Information Collection: Employee Building Pass Application and File;
Form No.: HCFA–730 & 182 (OMB# 0938–NEW);
Use: The purpose of this system and the forms are to control United States Government Building Passes issued to all HCFA employees and non-HCFA employees who require continuous access to HCFA buildings in Baltimore and other HCFA and HHS buildings.;
Frequency: Other; as needed;
Affected Public: Federal Government, and business or other for-profit;
Number of Respondents: 150;
Total Annual Responses: 150;
Total Annual Hours: 37.50.

(2) *Type of Information Collection Request:* Extension of a currently approved collection;
Title of Information Collection: Limitation on Liability and Information Collection Requirements Referenced in 42 CFR 411.404, 411.406, and 411.408;
Form No.: HCFA–R–77 (OMB# 0938–0465);
Use: The Medicare program requires to provide written notification of noncovered services to beneficiaries by the providers, practitioners, and

Office Building, Room 10235, Washington, D.C. 20503.

Dated: September 11, 2000.

John P. Burke III,

HCFA Reports Clearance Officer, HCFA, Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards.

[FR Doc. 00–25581 Filed 10–4–00; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

OIG Compliance Program for Individual and Small Group Physician Practices

AGENCY: Office of Inspector General (OIG), HHS.

ACTION: Notice.

SUMMARY: This **Federal Register** notice sets forth the recently issued Compliance Program Guidance for Individual and Small Group Physician Practices developed by the Office of Inspector General (OIG). The OIG has previously developed and published voluntary compliance program guidance focused on several other areas and aspects of the health care industry. We

Copies of these compliance program guidances can be found on the OIG web site at http://www.hhs.gov/oig.

Developing the Compliance Program Guidance for Individual and Small Group Physician Practices

On September 8, 1999, the OIG published a solicitation notice seeking information and recommendations for developing formal guidance for individual and small group physician practices (64 FR 48846). In response to that solicitation notice, the OIG received 83 comments from various outside sources. We carefully considered those comments, as well as previous OIG publications, such as other compliance program guidance and Special Fraud Alerts, in developing a guidance for individual and small group physician practices. In addition, we have consulted with the Health Care Financing Administration and the Department of Justice. In an effort to ensure that all parties had a reasonable opportunity to provide input into a final product, draft guidance for individual and small group physician practices was published in the **Federal Register** on June 12, 2000 (65 FR 36818) for further comments and recommendations.

Components of an Effective Compliance Program

The Components

1. Standards, Policies, and Procedures
2. Compliance Program Administration
3. Screening and Evaluation of Employees, Physicians, Vendors and other Agents
4. Communication, Education, and Training on Compliance Issues
5. Monitoring, Auditing, and Internal Reporting Systems
6. Discipline for Non-Compliance
7. Investigations and Remedial Measures

The Sources

- Payer
- Professional Organizations
- AMA

Documenting Medically Necessary Services

When do you document

What do you document

Sample Language from a Payer Contract or Provider Handbook

- Treatment record entries should be made on the date services are rendered and include the date of service; if an entry is made more than 24 hours after the service was rendered, the entry should include the date of service, date of the entry, and a notation that this is a late entry

Sample Language from a Payer Contract or Provider Handbook

- Provider shall maintain books, records, and other compilations of data pertaining to provision of the services to the extent and ***in such detail as shall properly substantiate claims for payment*** hereunder

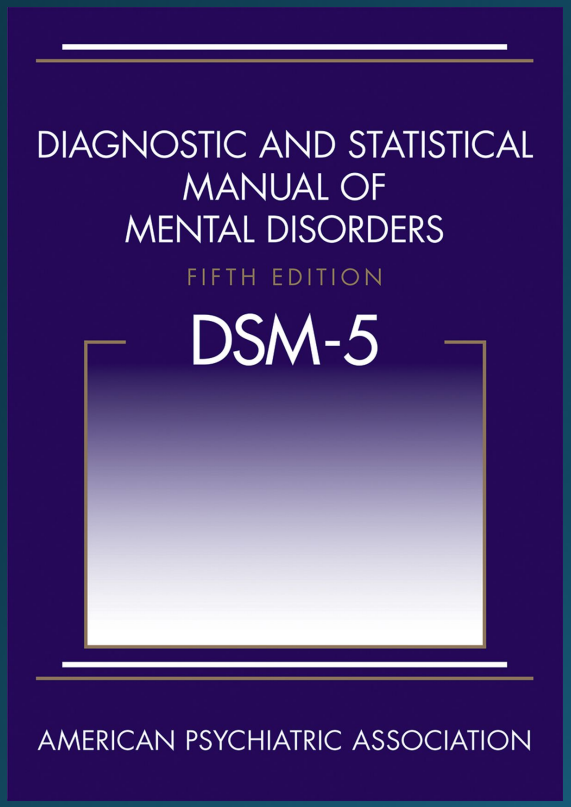
Sample Language from a Payer Contract or Provider Handbook

- Daily progress notes including:
  - place of service
  - start and stop time
  - who rendered the service
  - the specific service (e.g., caregiver guidance, direction of tech, direct service)
  - who attended the session
  - interventions that occurred during the session
  - barriers to progress
  - response to interventions

Sample Language from a Payer Contract or Provider Handbook

- The rendering clinicians must maintain ***narrative summaries that relate to the goals and objectives outlined in the beneficiary's treatment plan.*** These narrative summaries, also referred to as session notes, must correspond to ABA claims filed for that beneficiary.

Documenting Medically Necessary Services



- What services are you authorized to provide?
- What are the medical necessity criteria for that payer?
- What does the assessment reveal to be the core deficits on which you are basing your treatment plan and interventions?

Documenting Medically Necessary Services

Required Documentation		
Element	Payer	
	Payer 1	Payer 2
There must be a diagnosis of a condition on the Autism Spectrum (DSM: 299-299.9; ICD-10: F84-F84.9)	X	X
There are identifiable target behaviors having an impact on development, communication, interaction with typically developing peers or others in the child's environment, or adjustment to the settings in which the child functions, such that the child cannot adequately participate in developmentally appropriate essential community functions, such as school.	X	X
ABA is not custodial in nature (defined as care provided when the member "has reached the maximum level of physical or mental function and such person is not likely to make further significant improvement" or "any type of care where the primary purpose of the type of care provided is to attend to the member's daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel.")	X	

Common Documentation Errors per CMS

- Notes do not include all elements of eligibility (do not support procedure code used)
- Documentation does not support medical necessity (by payer definition or services are not aligned with assessment and resulting treatment plan)
- Missing signature or the signature cannot be properly authenticated

Tales from the Front

"Provider didn't keep good records – session notes weren't signed by the therapist. Insurance audit resulted in significant recoupment."

Tales from the Front

"As much as I truly question the agency's administration practices and customer support skills, the BCBA and therapist working with our child have been wonderful. So I am desperate to find a way to make things work."

Autism Insurance Resource Center – Parent Inquiry

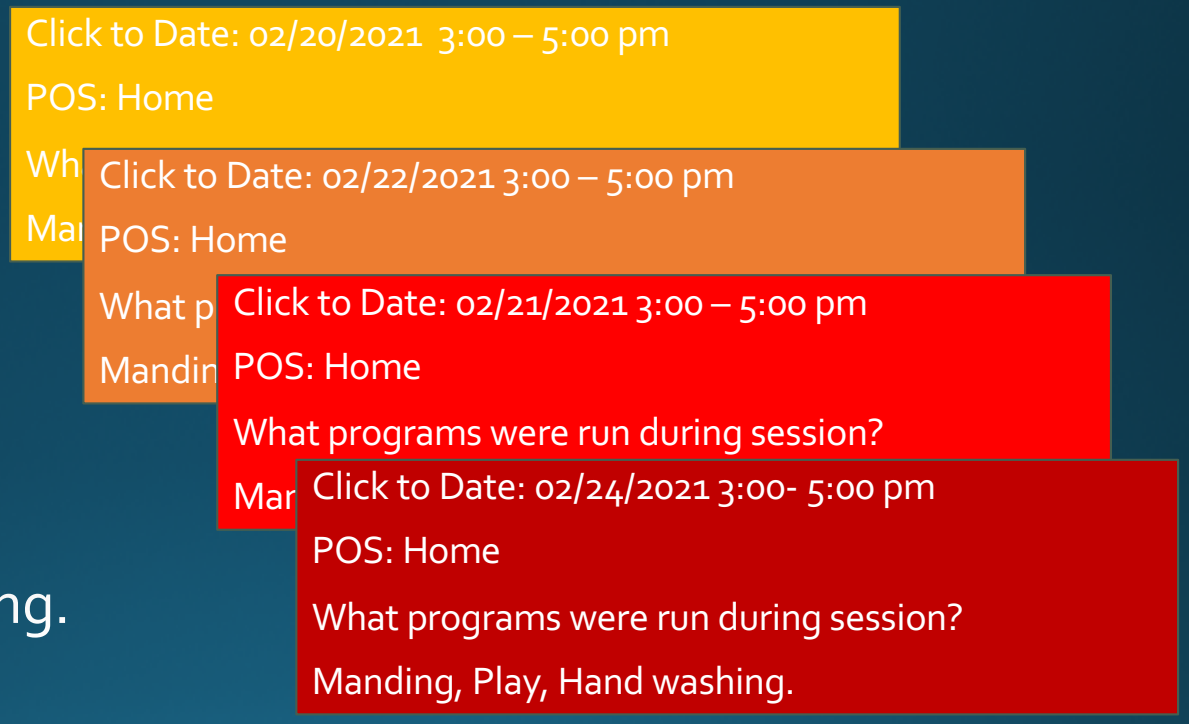
Sample Direct Service Note: 97153

Date: 02/18/2021 3 – 5 pm

POS: Home

What programs were run?

Manding, Play, Hand washing.



Documenting an Assessment

Sample Intake/Reassessment

Session Notes [H0031-U2]

Sample Assessment Narrative

H0031-U2

2/22/2021: 5 hours

Conducted indirect assessment with caretakers, observed client play with siblings, during mealtime and preparing for a nap. No challenging behaviors observed. Conducted direct assessment (ABLLS).

2/24/2021: 3 hours

Analyzed results of assessment and reviewed data, wrote report. Presented results to clinical director as family reported dangerous behavior.

ABA MassHealth Service Definitions

Non-reimbursable activities

- Staff meetings/professional development/staff trainings
  - This also includes members of the same organization meeting to discuss a client without the Member present.
- Completion of agency-related administrative documentation
  - e.g., travel vouchers, time sheets, and billing logs
- Breaks (including lunch)
- Checking Member eligibility
- Time spent completing authorization/review with MassHealth managed care plans
- Report writing
- Travel
- Development of visual aids, social stories, and other tools except when created with the child/caretaker(s)
- Parent training groups

Tales from the Front

3 year old started receiving ABA in January. Family gave insurance cards (private and MassHealth (MH)) to provider. They were told everything was set, and services started. Provider hadn't checked MH Electronic Verification System. Months later MH rejects claims because child didn't have Behavioral Benefits in their MH Plan. Provider tries to bill family, violating balance billing clause of MH contract, then threatens to terminate services, creating potential ethical violation.

Documenting Medically Necessary Services

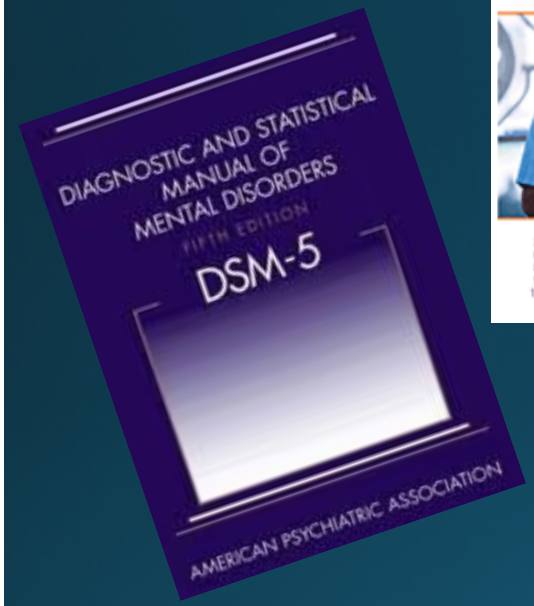
Generally accepted Medical Necessity Definition:

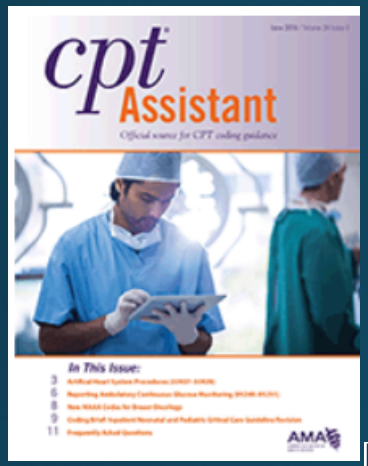
Medically necessary services are to *ameliorate* the symptoms and other effects of diagnosed conditions in order to enhance health and safety, improve overall functioning, and prevent deterioration and regression.

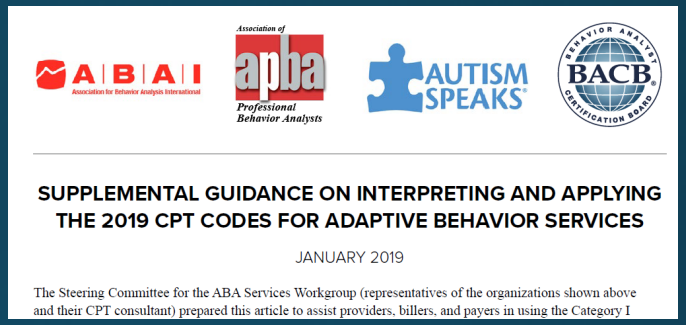
Documenting Medically Necessary Services

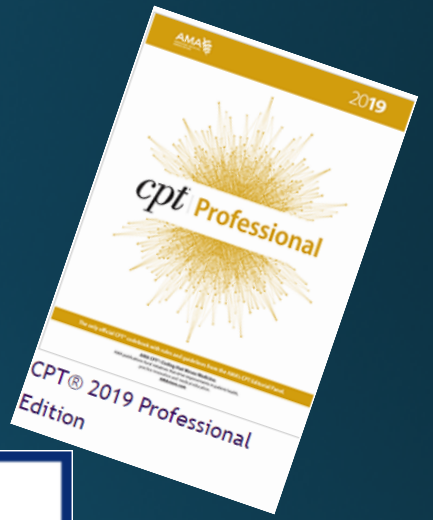
1. Diagnostic assessment and any updates or additional diagnostic testing done at the outset or during the treatment episode
2. The Individualized Action/Treatment Plan and any reviews, updates or modifications,
3. Each and every progress note which must describe an ordered, covered service that is necessary to realize the clinical outcomes of treatment.

Documenting Medically Necessary Services









CPT Codes: Adaptive Behavior Services

"Adaptive behavior services address deficient adaptive behaviors (eg, impaired social, communication, or self-care skills), maladaptive behaviors (eg, repetitive and stereotypic behaviors, behaviors that risk physical harm to the patient, others ,and/or property),or other impaired functioning secondary to deficient adaptive or maladaptive behaviors, including but not limited to instruction-following, verbal and nonverbal communication, imitation, play and leisure, social interactions, self-care daily living, and personal safety"
-CPT Manual pg 710

Session Notes Compliance to Funder

Session Note Checklist

- ❑ patient name
- ❑ place of service
- ❑ date of service
- ❑ start and stop time
- ❑ total time
- ❑ total units
- ❑ who rendered the service
- ❑ rendering providers credentials
- ❑ the specific service CPT code (e.g., caregiver guidance, direction of tech, direct service)
- ❑ who attended the session
- ❑ 2 patient identifiers
- ❑ rendering provider's NPI #

Session Notes Compliance to Funder

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- ❑ patient name
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Session Note Header

97153 "(ABA Provider)" Insurance Session Notes

Patient: Susy Smith
DOB: 12/08/2017
Client ID: MH4398533

CPT Code: 97153
Provider: Stephanie Jones
Credentials: RBT
NPI: 89737298

Session Date: 02/14/2021
Session Start / End Time: 08:00 AM / 09:15 AM
Total Time: 1:15 H **Total Units:** 5 Units
Location of Services: 12-Home
Others Present: Rocky Star, BCBA and sibling

Session Notes Compliance to Funder

Session Note Checklist

- ☑ patient name
- ☑ place of service
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Session Notes Compliance to Funder

Session Note Checklist

- ❑ interventions that occurred during the session
- ❑ session narrative
- ❑ response to interventions
- ❑ verifiable Signature
- ❑ date form filled out with signature
- ❑ credentials by signature
- ❑ rendering providers credentials near signature

Session Notes Compliance to Funder

Summary of Techniques/Treatment Protocol Used During Session (Check all that apply): ✓

- ☐ Differential reinforcement (DRO, DRA, DRI)
- ☐ Planned ignoring
- ☐ Prompting/Fading
- ☐ Generalization
- ☐ Activity schedules
- ☐ Self-management
- ☐ Preference assessment
- ☐ Forward chaining
- ☐ Backward chaining
- ☐ Total task presentation
- ☐ Shaping
- ☐ Discrete-trial teaching
- ☐ Pairing of Behavior Tech and Child
- ☐ Maintenance procedures
- ☐ Schedules of reinforcement
- ☐ Behavioral momentum
- ☐ Incidental teaching/NET

Session Narrative Summary/Response to Intervention: ✓

COMMUNICATION
Patient was able to receptively identity/gather items based on the function of the object for 3 different items including broom and bag with only leading questions prompts. Patient was able to expressively label pictures of actions the two new action targets of actions with objects including clean with broom independently. ✓

SOCIAL INTERACTION
When putting away activities Patient was able to scan the environment and say "book" and point to where the item was when asked "where is book?" Patient was able to follow 3 simple motor actions when modeled to complete a close ended play activity with an another novel adult. When walking into library, Patient stopped singing and lowered volume appropriately. ✓

RESTRICTED, REPETITIVE PATTERNS OF BEHAVIOR, INTERESTS, OR ACTIVITIES TREATMENT GOALS
When peer walked by room, Patient ran out/eloped of the room down hallway to join peer, and returned to activity room when told "you need to come back to finish the game with me" and they came back to the room. When transitioning to leave center/a new activity Patient began crying and hit BT but was redirectable when shown activity schedule of what will happen when they got home. No other crying episodes were identified. ✓

Rendering Provider's Signature: ✓

Thea Davis

Date Signed: 2/14/21 ✓

Rendering Provider's Credentials:

BCBA, LABA ✓

Session Note Checklist

- ☑ interventions that occurred during the session ✓
- ☑ session narrative ✓
- ☑ response to interventions ✓
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Connecting The IPN to Sources

IPN

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Signs / Symptoms Observed During Session (Check all that apply):

Deficits in Adaptive Behaviors

Communication:
- ☐ Receptive language/ instruction-following
- ☐ Expressive language/ vocal/verbal

Social:
- ☐ Play skills
- ☐ Leisure skills
- ☐ Imitation
- ☐ Sharing imaginative play
- ☐ Sharing imaginative play with peers (including social role play)
- ☐ Imitation

Social Interactions:
- ☐ coordinated verbal and non-verbal (eg. eye contact/body language with words)
- ☐ Sharing of interests/joint attention
- ☐ Use and understanding of body postures (e.g. facing away from listener)
- ☐ Use and understanding of gestures (eg pointing, nodding/shaking head, waving)
- ☐ Coordinated nonverbal communication(eg eye contact with gestures)
- ☐ Adjusting behavior to context
- ☐ Sharing of emotions/affect
- ☐ Interest in others (eg. Peers, prefers solitary activities, withdrawn)

Maladaptive and Interfering Behaviors

- ☐ Repetitive speech (eg. jargon, rote language, idiosyncratic phrases, echolalia)
- ☐ Repetitive motor movements (e.g. hand flapping, rocking, covering ears)
- ☐ Repetitive use of objects (e.g. non-functional play, lining toys, turns lights on and off, open/close doors)
- ☐ Body tensing / toe walking
- ☐ Restricted/Repetitive/ Stereotypic Behaviors, Hyper/hypo reactivity to sensory input
- ☐ Excessive adherence to routines/patterns unusual multistep sequences of behaviors
- ☐ Highly restrictive interests (eg. Preoccupation with numbers, letters, colors, historical events, trains,
- ☐ Excessive resistance to change
- ☐ Unusual visual exploration/ activity (e.g. squinting, look at objects out of the corner of eye)
- ☐ Unusual response to sound, smell, taste, vestibular
- ☐ Unusual sensory exploration with objects (licking/sniffing objects)
- ☐ Preoccupation with textures or touch (e.g. Tactile defensiveness: won't touch certain textures, aversion to hair brushed, toenails cut, etc)

Behaviors that risk physical harm to patient or others

- ☐ Aggression to others (e.g. hitting, kicking, biting, etc)
- ☐ Elopement
- ☐ Non-compliance
- ☐ Self injury (e.g. Headbanging, hitting self, etc)
- ☐ Tantrums
- ☐ Property destruction (e.g. throwing items)
- ☐ Dropping to floor

Summary of Techniques/Treatment Protocol Used During Session (Check all that apply):

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- ☐ Planned ignoring
- ☐ Prompting/Fading
- ☐ Generalization
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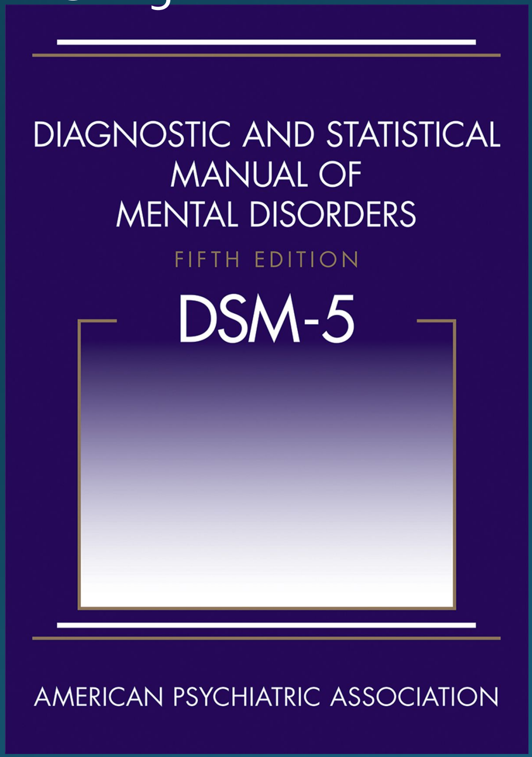
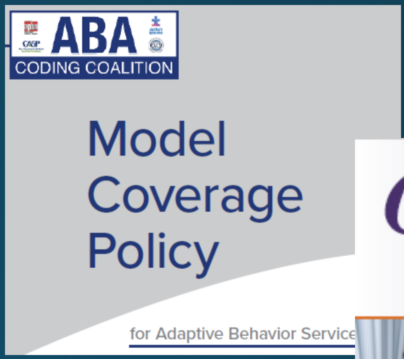
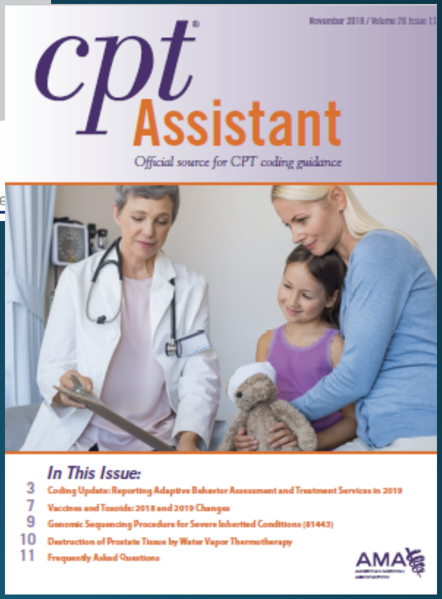
DSM-5



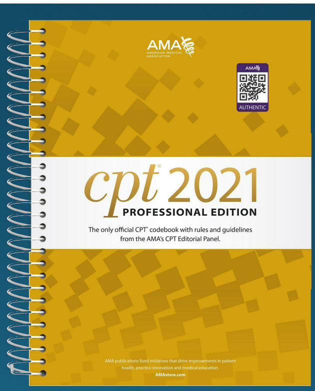
ABA Model Coverage



CPT Assistant



CPT Manual



Documenting Sessions CPT code 97153

97153 Adaptive Behavior Treatment by Protocol

1. Face to face **[billable time]**

   Implements a treatment protocol designed in advance by QHP/BCBA

2. Non face to face: Pre/Post work **[not billable time]**

Examples:

Reviews

- PBSP operational definitions of behaviors
- Skill target definition
- Modification to written protocols
- Graph data from session

The Process

97153: Connecting the IPN to the CPT Manual

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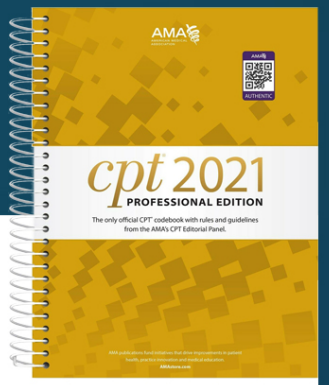
Maladaptive and Interfering Behaviors

- ☐ Repetitive speech (eg. jargon, rote language, idiosyncratic phrases, echolalia)
- ☐ Repetitive motor movements (e.g. hand flapping, rocking, covering ears)
- ☐ Restricted/Repetitive/ Stereotypic Behaviors, Hyper/hypo reactivity to sensory input
- ☐ Excessive adherence to routines/patterns unusual multistep sequences of behaviors
- ☐ Unusual visual exploration/ activity (e.g. squinting, look at objects out of the corner of eye)
- ☐ Unusual response to sound, smell, taste, vestibular



"Adaptive behavior services address deficient adaptive behaviors (eg, impaired social, communication, or self-care skills), maladaptive behaviors (eg, repetitive and stereotypic behaviors, behaviors that risk physical harm to the patient, others ,and/or property),or other impaired functioning secondary to deficient adaptive or maladaptive behaviors, including but not limited to instruction-following, verbal and nonverbal communication, imitation, play and leisure, social interactions, self-care daily living, and personal safety"

-CPT Manual pg 710

The Process

97153: Connecting the IPN to DSM-5

97153 "(ABA Provider)" Insurance Session Notes

Patient: Susy Smith
DOB: 12/08/2017
Client ID: MH4398533

CPT Code: 97153
Provider: Stephanie Jones
Credentials: RBT
NPI: 89737298

Session Date: 02/14/2021
Session Start / End Time: 08:00 AM / 09:15 AM
Total Time: 1:15 H **Total Units:** 5 Units
Location of Services: 12-Home
Others Present: Rocky Star, BCBA and sibling

Signs / Symptoms Observed During Session (Check all that apply):

Deficits in Adaptive Behaviors

Communication:

- ☐ Receptive language/ instruction-following
- ☐ Expressive language/ vocal/verbal

Social:

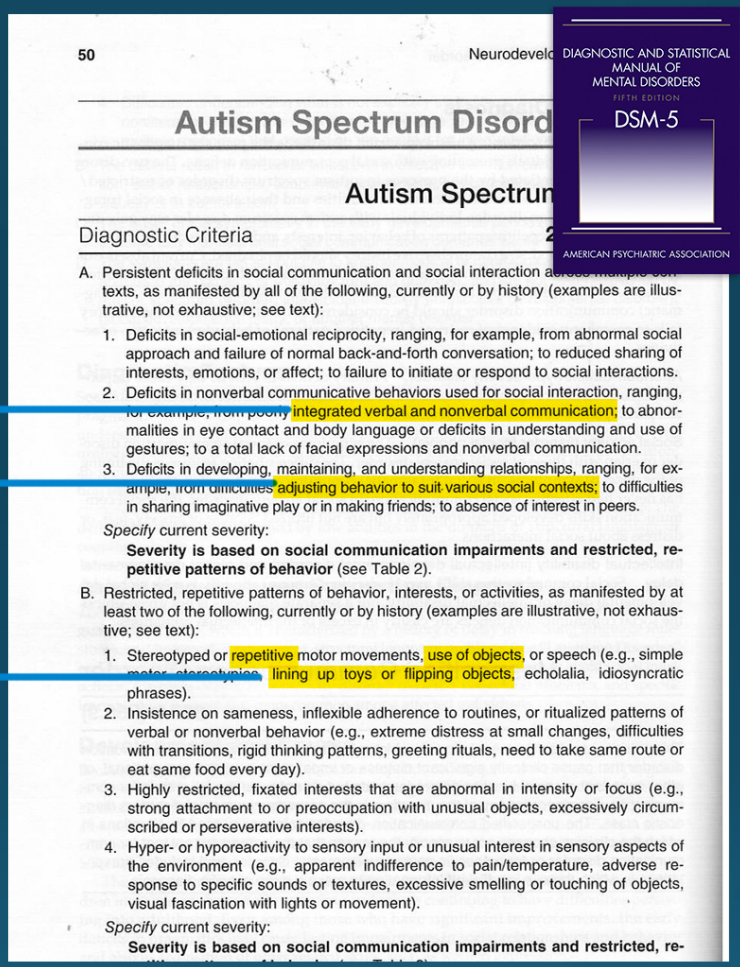
- ☐ Play skills
- ☐ Leisure skills
- ☐ Imitation
- ☐ Sharing imaginative play
- ☐ Sharing imaginative play with peers (including social role play)
- ☐ Imitation

Social Interactions:

- ☐ coordinated verbal and non-verbal (eg. eye contact/body language with words)
- ☐ Sharing of interests/joint attention
- ☐ Use and understanding of body postures (e.g. facing away from listener)
- ☐ Use and understanding of gestures (eg pointing, nodding/shaking head, waving)
- ☐ Coordinated nonverbal communication(eg eye contact with gestures)
- ☐ Adjusting behavior to context
- ☐ Sharing of emotions/affect
- ☐ Interest in others (eg. Peers, prefers solitary activities, withdrawn)

Maladaptive and Interfering Behaviors

- ☐ Repetitive speech (eg. jargon, rote language, idiosyncratic phrases, echolalia)
- ☐ Repetitive motor movements (e.g. hand flapping, rocking, covering ears)
- ☐ Repetitive use of objects (e.g. non-functional play, lining toys, turns lights on and off, open/close doors)
- ☐ Body tensing / toe walking
- ☐ Restricted/Repetitive/ Stereotypic Behaviors, Hyper/hypo reactivity to sensory input
- ☐ Excessive adherence to routines/patterns unusual multistep sequences of behaviors
- ☐ Highly restrictive interests (eg. Preoccupation with numbers, letters, colors, historical events, trains,
- ☐ Excessive resistance to change
- ☐ Unusual visual exploration/ activity (e.g. squinting, look at objects out of the corner of eye)
- ☐ Unusual response to sound, smell, taste, vestibular
- ☐ Unusual sensory exploration with objects (licking/sniffing objects)
- ☐ Preoccupation with textures or touch (e.g. Tactile defensiveness: won't touch certain textures, aversion to



50 Neurodevelo

Autism Spectrum Disord

Autism Spectrun

Diagnostic Criteria

A. Persistent deficits in social communication and social interaction a texts, as manifested by all of the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

Specify current severity:
Severity is based on social communication impairments and restricted, repetitive patterns of behavior (see Table 2).

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
4. Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

Specify current severity:
Severity is based on social communication impairments and restricted, re-

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS
FIFTH EDITION
DSM-5
AMERICAN PSYCHIATRIC ASSOCIATION

The Process

97153: Connecting the IPN to DSM-5

Maladaptive and Interfering Behaviors

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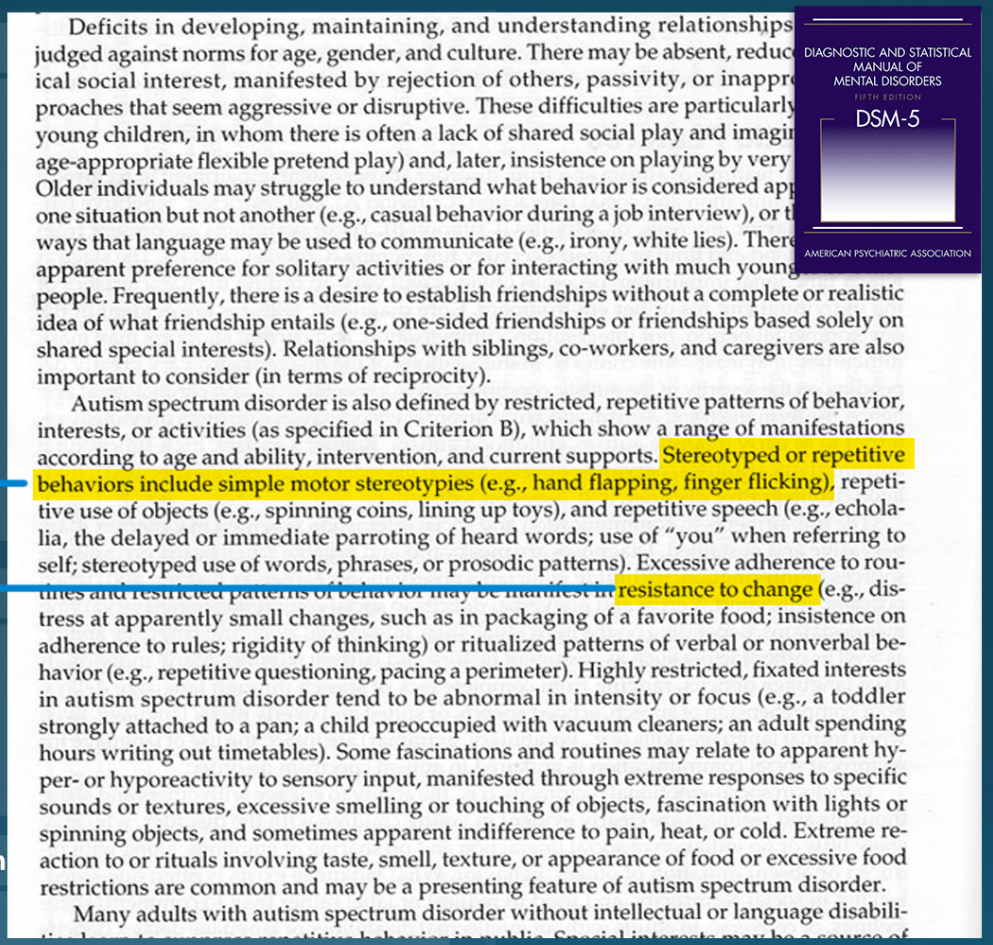
- ☐ Body tensing / toe walking
- ☐ Restricted/Repetitive/ Stereotypic Behaviors, Hyper/hypo reactivity to sensory input
- ☐ Excessive adherence to routines/patterns unusual multistep sequences of behaviors
- ☐ Highly restrictive interests (eg. Preoccupation with numbers, letters, colors, historical events, trains,
- ☐ Excessive resistance to change

Behaviors that risk physical harm to patient or others

- ☐ Aggression to others (e.g. hitting, kicking, biting, etc)
- ☐ Elopement
- ☐ Non-compliance
- ☐ Self injury (e.g. Headbanging, hitting self, etc)
- ☐ Tantrums

Summary of Techniques/Treatment Protocol Used During Session (Check all th

- ☐ Differential reinforcement (DRO, DRA, DRI)
- ☐ Planned ignoring
- ☐ Prompting/Fading
- ☐ Preference assessment
- ☐ Forward chaining
- ☐ Backward chaining
- ☐ Maintenance procedures
- ☐ Schedules of reinforcement



Deficits in developing, maintaining, and understanding relationships judged against norms for age, gender, and culture. There may be absent, reduc ical social interest, manifested by rejection of others, passivity, or inappr proaches that seem aggressive or disruptive. These difficulties are particularly young children, in whom there is often a lack of shared social play and imagi age-appropriate flexible pretend play) and, later, insistence on playing by very Older individuals may struggle to understand what behavior is considered ap one situation but not another (e.g., casual behavior during a job interview), or t ways that language may be used to communicate (e.g., irony, white lies). There apparent preference for solitary activities or for interacting with much young people. Frequently, there is a desire to establish friendships without a complete or realistic idea of what friendship entails (e.g., one-sided friendships or friendships based solely on shared special interests). Relationships with siblings, co-workers, and caregivers are also important to consider (in terms of reciprocity).

Autism spectrum disorder is also defined by restricted, repetitive patterns of behavior, interests, or activities (as specified in Criterion B), which show a range of manifestations according to age and ability, intervention, and current supports. Stereotyped or repetitive behaviors include simple motor stereotypies (e.g., hand flapping, finger flicking), repetitive use of objects (e.g., spinning coins, lining up toys), and repetitive speech (e.g., echolalia, the delayed or immediate parroting of heard words; use of "you" when referring to self; stereotyped use of words, phrases, or prosodic patterns). Excessive adherence to routines and restricted patterns of behavior may be manifest in resistance to change (e.g., distress at apparently small changes, such as in packaging of a favorite food; insistence on adherence to rules; rigidity of thinking) or ritualized patterns of verbal or nonverbal behavior (e.g., repetitive questioning, pacing a perimeter). Highly restricted, fixated interests in autism spectrum disorder tend to be abnormal in intensity or focus (e.g., a toddler strongly attached to a pan; a child preoccupied with vacuum cleaners; an adult spending hours writing out timetables). Some fascinations and routines may relate to apparent hyper- or hyporeactivity to sensory input, manifested through extreme responses to specific sounds or textures, excessive smelling or touching of objects, fascination with lights or spinning objects, and sometimes apparent indifference to pain, heat, or cold. Extreme reaction to or rituals involving taste, smell, texture, or appearance of food or excessive food restrictions are common and may be a presenting feature of autism spectrum disorder.

Many adults with autism spectrum disorder without intellectual or language disabili-

The Process

97153: Connecting the IPN to the ABA Model Coverage Policy

Behaviors that risk physical harm to patient or others

- ☐ Aggression to others (e.g. hitting, kicking, biting, etc)
- ☐ Self injury (e.g. Headbanging, hitting self, etc)
- ☐ Property destruction (e.g. throwing items)
- ☐ Elopement
- ☐ Tantrums
- ☐ Dropping to floor
- ☐ Non-compliance

Summary of Techniques/Treatment Protocol Used During Session (Check all that apply):

- ☐ Differential reinforcement (DRO, DRA, DRI)
- ☐ Preference assessment
- ☐ Pairing of Behavior Tech and Child
- ☐ Planned ignoring
- ☐ Forward chaining
- ☐ Maintenance procedures
- ☐ Prompting/Fading
- ☐ Backward chaining
- ☐ Schedules of reinforcement
- ☐ Generalization
- ☐ Total task presentation
- ☐ Behavioral momentum
- ☐ Activity schedules
- ☐ Shaping
- ☐ Incidental teaching/NET
- ☐ Self-management
- ☐ Discrete-trial teaching

Session Narrative Summary/Response to Intervention:

COMMUNICATION
Patient was able to receptively identity/gather items based on the function of the object for 3 different items including broom and bag with only leading questions prompts. Patient was able to expressively label pictures of actions the two new action targets of actions with objects including clean with broom independently.

SOCIAL INTERACTION
When putting away activities Patient was able to scan the environment and say "book" and point to where the item was when asked "where is book?" Patient was able to follow 3 simple motor actions when modeled to complete a close ended play activity with an another novel adult. When walking into library, Patient stopped singing and lowered volume appropriately.

RESTRICTED, REPETITIVE PATTERNS OF BEHAVIOR, INTERESTS, OR ACTIVITIES TREATMENT GOALS
When peer walked by room, Patient ran out/eloped of the room down hallway to join peer, and returned to activity room when told "you need to come back to finish the game with me" and they came back to the room. When transitioning to leave center/a new activity Patient began

Indications
Behavior analysis is a natural science discipl
matter is behavior interacting with environ
behavior analysis (ABA) involves applying s
procedures discovered through basic and a
improve socially important behaviors to a n
Extensive research conducted since the 19
efficacy of scores of ABA procedures – singly and
in various combinations – for building useful skills and reducing problem behaviors in many clinical and nonclinical populations. In particular, when designed and overseen by qualified professionals, ABA treatments have proved effective for ameliorating symptoms, developing adaptive behaviors, and reducing maladaptive behaviors so as to enhance healthy, successful functioning and prevent deterioration and regression in patients with disorders that arise during the developmental period. Those include but are not limited to autism spectrum disorder, intellectual and other developmental disabilities, attention-deficit/hyperactivity disorder, brain injuries and diseases, movement disorders, feeding disorders, and behavior disorders. 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.

The Process

97153: Connecting the IPN to the ABA Model Coverage Policy

Behaviors that risk physical harm to patient or others

- ☐ Aggression to others (e.g. hitting, kicking, biting, etc)
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ABA procedures
A large array of ABA procedures has proved effective for developing adaptive behaviors and reducing maladaptive behaviors. All of the procedures are based on the principles of behavior analysis. They include but are 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. The discipline of behavior analysis is constantly developing and evaluating applied behavior-change procedures. The behavior analyst selects the procedures to incorporate in each individual patient's treatment plan based on results of

The Process

97153: Connecting the IPN to the Treatment Plan

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When peer walked by room, Patient ran out/eloped of the room down hallway to join peer, and returned to activity room when told "you need to come back to finish the game with me" and they came back to the room. When transitioning to leave center/a new activity Patient began crying and hit BT but was redirectable when shown activity schedule of what will happen when they got home. No other crying episodes were identified.

Rendering Provider's Signature:

Thea Davis

Date Signed: 2/14/21

Rendering Provider's Credentials:

BCBA, LABA

INSURANCE TREATMENT PLAN PROGRESS

Patient: Patient Last Name
Member Number: XXXXXXX
Date of Birth: XXXX
Age at Progress: 3 years 4 months
Gender: Male
Referred By:
Date of Progress: 10/25/2021
Date Entered Program: 03/02/2020

I. **Biopsychosocial Information**

1) **Family Structure:**

Patient is a 3-year 4-month-old boy who lives in Town, State with his mother "Name", father "Name"and older sister "Name"

2) **Medical History**

Patient was diagnosed with Autism Spectrum Disorder (F84) and Global Developmental Delay (F88) on Jan 14, 2020 by "Name" MD, Developmental Behavioral Pediatrician and "Name" PhD, Psychologist from Boston Children's Hospital in Boston, MA.

3) **Medications**

None

4) **School Functioning**

Patient is 3-years 4-months old and does not yet attend school.

The Process

97153: Connecting the IPN to the Treatment Plan

Session Narrative Summary/Response to Intervention:

COMMUNICATION

Patient was able to receptively identity/gather items based on th function of the object for 3 different items including broom and bag with only leading questions prompts. Patient was able to expressively label pictures of actions the two new action targets c actions with objects including clean with broom independently.

SOCIAL INTERACTION

Wl d point to where the item was when a ked "where is
bc ose ended play activity with an another novel adult.
Wl

RE TREATMENT GOALS

Wl er, and returned to activity room when told "you need
to oning to leave center/a new activity Patient began
cr when they got home. No other crying episodes were
id

ing Provider's Credentials:

LABA

Date Introduced: N/A
October 2020: Patient vocally requests 2-word phrases using specific action/object words for the following 3 requests: eat (any object), open (any object) and read (book/title of book).

1. Patient will request using 3-word phrases comprise of specific action, attribute and object labels (e.g., "play red car") spontaneously or when asked "What do you want?" by the therapist with 100% accuracy in 4 out of 5 opportunities, as measured by therapist data and parents report across home and community environments. [A-1]

Date Introduced: N/A
October 2020: Patient receptively identifies a book when given its function. He does not yet label objects when the function is stated.

8. Given a field of 6 pictures of objects and the question "What do you (action) with?" Patient will label at least one object for 15 functions with 100% accuracy in 4 out of 5 opportunities as measured by the therapist' s data and parent report within the clinic and home environments. [A-1]

Patient Last Name
DOB: XXXX

1. **Biopsychosocial Information**

1) **Family Structure:**

Patient is a 3-year 4-month-old boy who lives in Town, State with his mother "Name", father "Name"and older sister "Name"

2) **Medical History**

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3) **Medications**

None

4) **School Functioning**

Patient is 3-years 4-months old and does not yet attend school.

The Process

97153: Connecting the IPN to the Treatment Plan

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RESTRICTED, REPETITIVE PATTERN S OF BEHAVIOR, INTERESTS, OR ACTIVITIES TREATMENT GOALS

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nsitioning to leave center/a new activity Patient beg
pen when they got home. No other crying episode

ndering Provider's Credentials:

BA, LABA

Date Introduced: N/A
October 2020: Patient follows a sequence of 2 motor directions with 72% accuracy when instructed.

18. Patient will follow a sequence of 3 simple motor directions (e.g., wave, clap, stomp, etc.) when asked by a familiar adult with 100% accuracy in 4 out of 5 opportunities as measured by the therapist' s data and parents report across home and community environments. [B-1]

Date Introduced: 9/1/2020
April 2020: Patient intermittently glances at adults during preferred activities indicating a desire to share interest. Demonstrating initiation of joint attention with objects will be targeted next.
October 2020: Patient initiates bids for joint attention with adults by holding up objects of interest while initiating eye contact. He is 76% accurate initiating bids with a vocal directive or comment about the item.

1. Patient will demonstrate initiation of joint attention by holding up an object of interest or pointing to a picture or object of interest in 4 out of 5 opportunities as measured by the therapist' s data and grandparent report across home and community environments. [A-1 and/or A-2] MET

Patient Last Name
DOB: XXXX

other "Name", father

Developmental Delay
an and "Name" PhD,

4) **School Functioning**

Patient is 3-years 4-months old and does not yet attend school.

The Process

97153: Connecting the IPN to the Treatment Plan

Session Narrative Summary/Response to Intervention:

COMMUNICATION

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Rendering Provider's Signature:

Thea Davis

Date Signed: 2/14/21

Rendering Provider's Credentials:

BCBA, LABA

31.Patient will reduce the rate of eloping by 20% from baseline as measured by therapist's data across home and community environments.
Baseline April 2020: Average of 1.00 per day
October 2020: Average of 0.33 per day

Patient Last Name
DOB: XXXX

INSURANCE TREATMENT PLAN PROGRESS

Last Name
er: XXXXXXX
XXXX
: 3 years 4 months

Date of Progress: 10/25/2021
Date Entered Program: 03/02/2020

I. **Biopsychosocial Information**

1) **Family Structure:**

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2) **Medical History**

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30. Patient will reduce the duration of crying by 20% from baseline as measured by therapist's data across home and community environments.
Baseline April 2020: Average of 1.08 minutes per day
October 2020: Average of 0.40 minutes per day
Decrease of 63%

Documenting Sessions CPT code 97155

97155 Adaptive Behavior treatment with protocol modification

1. Face to face with Patient **[billable time]**
    - Identifies one or more problems with protocol/s
    - May simultaneously direct a technician in administering modified protocol
2. Non face to face: Pre/Post work **[not billable time]**

Examples:

- Review BT Graphs
- Modify written protocols
- Create stimuli or materials

The Process

97155: Connecting the IPN to the CPT Manual

Summary of Activities Completed During Session (Check all that apply):

☐ 1:1 IMPLEMENTION WITH PATIENT: SYSTEMATIC TESTING/VARIED TREATMENT TO REFINE PROTOCOLS

- ☐ Implementation of protocol indicates need for change
  - ☐ New target
  - ☐ New prompt level
  - ☐ New instruction
  - ☐ New response criteria
  - ☐ New materials
- ☐ Tested a modified protocol

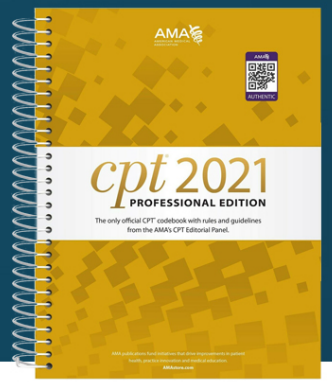
☐ SIMULTANEOUS DIRECTION OF BT IMPLEMENTING A NEW/MODIFIED TREATMENT PROTOCOL

- ☐ Modeling of treatment protocols
- ☐ Active direction of a BT while the BT delivers a service to the patient

List Directions Given:

Identify Adjustments to Protocol Components Needed

- ☐ New targets
- ☐ New protocol / program
- ☐ New measurement (frequency, duration)
- ☐ New prompt levels
- ☐ Context variables (i.e. generalization)
- ☐ New materials
- ☐ Reinforceers / reinforcer delivery
- ☐ New response criteria
- ☐ New instructions / new or modified Sd



#● **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

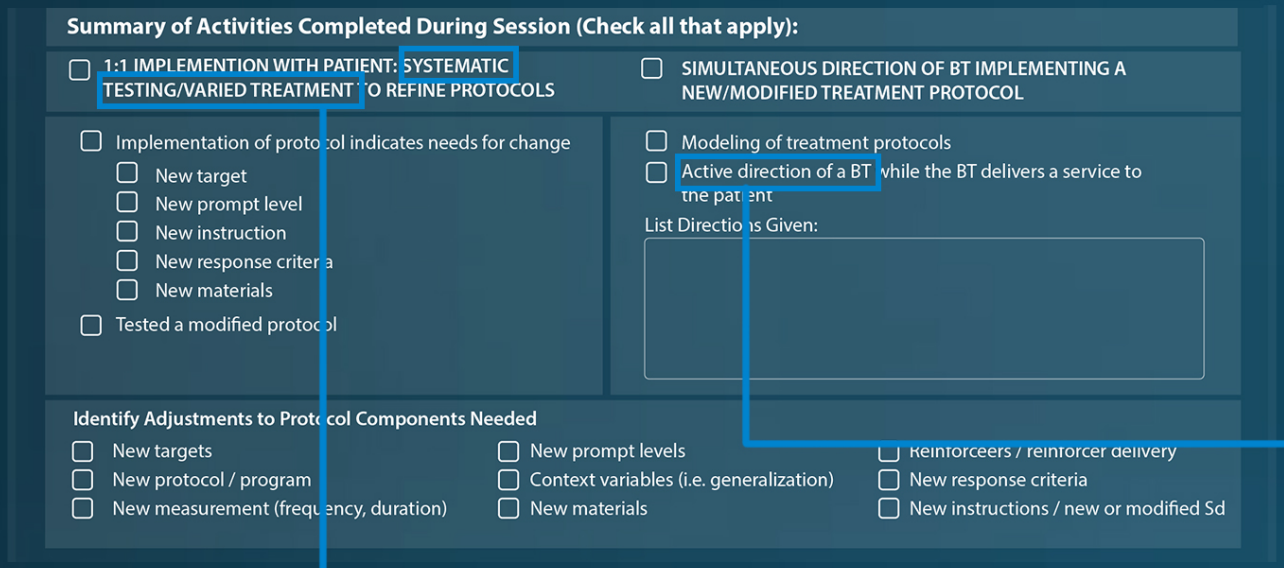
CPT Changes: An Insider's View 2019

►(Do not report 97155 in conjunction with 90785-90899, 96105-96155, 92507)◄

Adaptive behavior treatment with protocol modification (97155) is administered by a physician or other qualified health care professional face-to-face with a single patient. The physician or other qualified health care professional resolves one or more problems with the protocol and may simultaneously direct a technician in administering the modified protocol while the patient is present. Physician or other qualified health care professional direction to the technician without the patient present is not reported separately.

The Process

97155: Connecting the IPN to the ABA Model Coverage Policy



Summary of Activities Completed During Session (Check all that apply):

☐ 1:1 IMPLEMENTION WITH PATIENT: SYSTEMATIC TESTING/VARIED TREATMENT TO REFINE PROTOCOLS

- ☐ Implementation of protocol indicates needs for change
  - ☐ New target
  - ☐ New prompt level
  - ☐ New instruction
  - ☐ New response criteria
  - ☐ New materials
- ☐ Tested a modified protocol

☐ SIMULTANEOUS DIRECTION OF BT IMPLEMENTING A NEW/MODIFIED TREATMENT PROTOCOL

- ☐ Modeling of treatment protocols
- ☐ Active direction of a BT while the BT delivers a service to the patient

List Directions Given:

Identify Adjustments to Protocol Components Needed

- ☐ New targets
- ☐ New protocol / program
- ☐ New measurement (frequency, duration)
- ☐ New prompt levels
- ☐ Context variables (i.e. generalization)
- ☐ New materials
- ☐ Reinforcers / reinforcer delivery
- ☐ New response criteria
- ☐ New instructions / new or modified Sd

Page 7

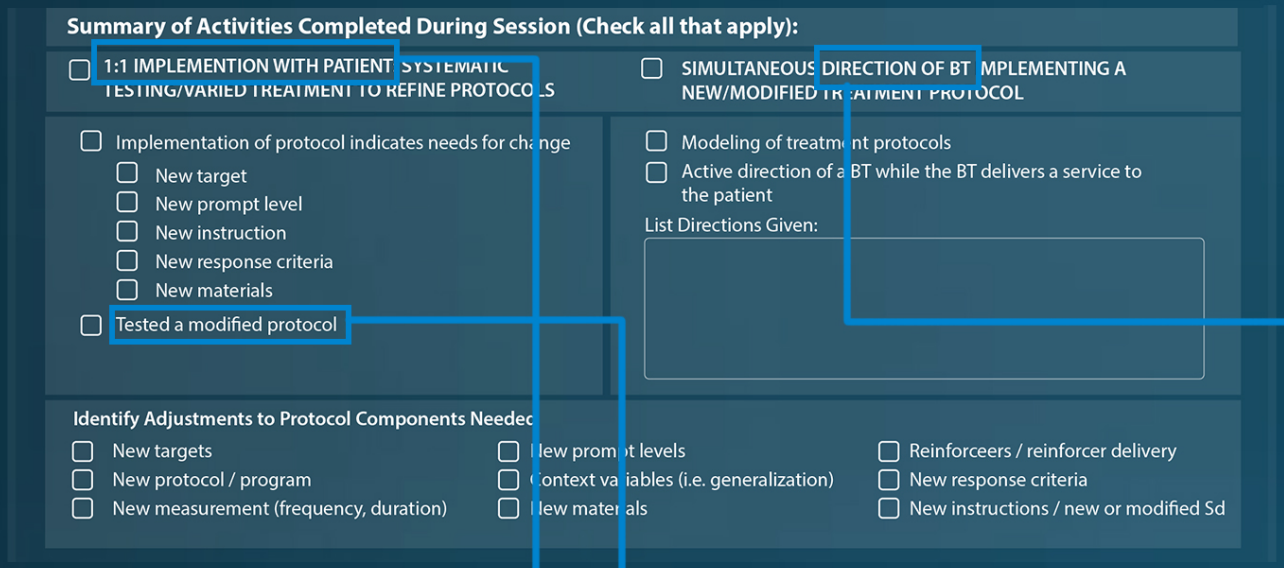
Code 97155 services should be reimbursed only if (a) a QHP works directly with the patient to observe changes in behavior or troubleshoot treatment protocols, or (b) the QHP joins the patient and the technician during a treatment session to direct the technician in implementing a new or modified treatment protocol.

Page 21

Treatment Code 97155: The medical record must reflect that (a) the required elements of the code are met; (b) the QHP observed a technician implement the treatment protocol and made refinements as ~~indicated,~~ or implemented and systematically varied the treatment in order to refine the protocol; and (c) the treatment was medically necessary.

The Process

97155: Connecting the IPN to the Supplemental Guidance



Summary of Activities Completed During Session (Check all that apply):

☐ 1:1 IMPLEMENTION WITH PATIENT SYSTEMATIC TESTING/VARIED TREATMENT TO REFINE PROTOCOLS

- ☐ Implementation of protocol indicates needs for change
  - ☐ New target
  - ☐ New prompt level
  - ☐ New instruction
  - ☐ New response criteria
  - ☐ New materials
- ☐ Tested a modified protocol

☐ SIMULTANEOUS DIRECTION OF BT IMPLEMENTING A NEW/MODIFIED TREATMENT PROTOCOL

- ☐ Modeling of treatment protocols
- ☐ Active direction of a BT while the BT delivers a service to the patient

List Directions Given:

Identify Adjustments to Protocol Components Needed

- ☐ New targets
- ☐ New protocol / program
- ☐ New measurement (frequency, duration)
- ☐ New prompt levels
- ☐ Context variables (i.e. generalization)
- ☐ New materials
- ☐ Reinforceers / reinforcer delivery
- ☐ New response criteria
- ☐ New instructions / new or modified Sd

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observations to determine if the protocol components are functioning effectively for the patient or require adjustments; (c) active direction of a technician while the technician delivers a service to a patient to ensure that the procedures are being implemented correctly, to correct errors in implementation, or to train the technician to implement a modified protocol; and (d) QHP implementation of the protocol with the patient to determine if changes are needed to improve patient progress or to test a modified protocol. Any protocol-modification services that are delivered during face-to-face sessions with patients or caregivers are billable. Modifying written protocols is an indirect service that is not reported separately, but is bundled with 97155 for payment.

Q: When do I report 97155?

A: In two cases: (1) When a QHP conducts 1:1 direct treatment with the patient to observe changes in behavior or troubleshoot treatment protocols; or (2)

Documenting Sessions CPT code 97156

97156 Family adaptive behavior treatment guidance

1.Face to face with guardian/caregiver with or without patient present **[billable time]**

- Identify potential treatment targets
- Training guardian/caregiver to implement treatment protocols designed to address deficient adaptive or maladaptive behaviors.

2. Non face to face: Pre/Post work **[not billable time]**

Examples:

1. Graph results of the session
2. Design plan of action for protocol changes

The Process

97156: Connecting the IPN to the CPT Manual

Summary of Activities Completed During Session (Check all that apply):

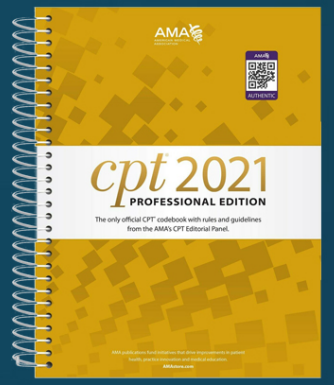
LIST PROTOCOLS DISCUSSED/MODELED

- ☐ Requesting / manding
- ☐ Positive behavior support plan
- ☐ Antecedent modification implementation
- ☐ Consequence implementation
- ☐ Prompting implementation
- ☐ Reinforcement / reinforcer delivery
- ☐ Instructions to patient delivery
- ☐ Identified potential targets

FAMILY ADAPTIVE BEHAVIOR TREATMENT GUIDANCE

- ☐ Review treatment protocol
- ☐ Modeled treatment protocol for caregiver
- ☐ List directions given:

☐ **Recorded Data on Caregiver Implementation**



Family adaptive behavior treatment guidance and **multiple-family group adaptive behavior treatment guidance** (97156, 97157) are administered by a physician or other qualified health care professional face-to-face with guardian(s)/caregiver(s) and involve identifying potential treatment targets and training guardian(s)/caregiver(s) of one patient (97156) or multiple patients (97157) to implement treatment protocols designed to address deficient adaptive or maladaptive behaviors. Services described by 97156 may be performed with or without the patient present. Services described by 97157 are performed without the patient present. Do not report 97157 if the group has more than eight patients' guardian(s)/caregiver(s).

The Process

97156: Connecting the IPN to the CPT Assistant

Summary of Activities Completed During Session (Check all that apply):

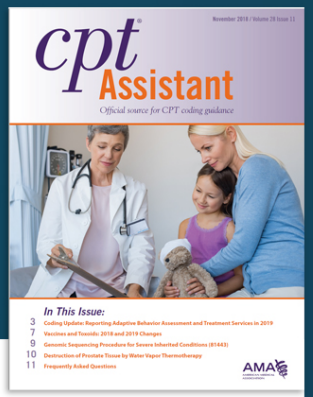
LIST PROTOCOLS DISCUSSED/MODELED

- ☐ Requesting / manding
- ☐ Positive behavior support plan
- ☐ Antecedent modification implementation
- ☐ Consequence implementation
- ☐ Prompting implementation
- ☐ Reinforcement / reinforcer delivery
- ☐ Instructions to patient delivery
- ☐ Identified potential targets

FAMILY ADAPTIVE BEHAVIOR TREATMENT GUIDANCE

- ☐ Review treatment protocol
- ☐ Modeled treatment protocol for caregiver
- ☐ List directions given:

☐ **Recorded Data on Caregiver Implementation**



Family Treatment Guidance

Family adaptive behavior treatment guidance and multiple-family group adaptive behavior treatment guidance (97156, 97157) are administered by a physician/other QHP face-to-face with guardian(s)/caregiver(s) and involve identifying potential treatment targets and training guardian(s)/caregiver(s) of one patient (97156) or multiple patients (97157) to implement treatment protocols to help reduce maladaptive behaviors and reinforce appropriate behaviors. The treatment represented by code 97156 may be performed with or without the patient present. The treatment represented by code 97157 is performed without the patient present.◆

The Process

97156: Connecting the IPN to the ABA Model Coverage Policy

Summary of Activities Completed During Session (Check all that apply):

LIST PROTOCOLS DISCUSSED/MODELED

- ☐ Requesting / manding
- ☐ Positive behavior support plan
- ☐ Antecedent modification implementation
- ☐ Consequence implementation
- ☐ Prompting implementation
- ☐ Reinforcement / reinforcer delivery
- ☐ Instructions to patient delivery
- ☐ Identified potential targets

FAMILY ADAPTIVE BEHAVIOR TREATMENT GUIDANCE

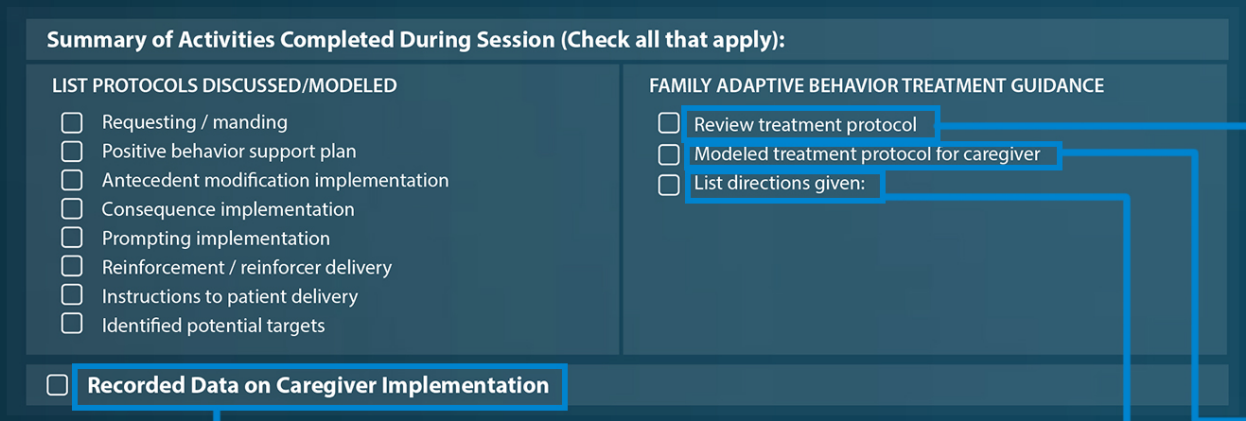
- ☐ Review treatment protocol
- ☐ Modeled treatment protocol for caregiver
- ☐ List directions given:

☐ **Recorded Data on Caregiver Implementation**

Support and training of family members and other caregivers to promote generalization and maintenance of behavioral improvements, to the extent that is practical given family circumstances.

The Process

97156: Connecting the IPN to the Supplemental Guidance



Summary of Activities Completed During Session (Check all that apply):

LIST PROTOCOLS DISCUSSED/MODELED

- ☐ Requesting / manding
- ☐ Positive behavior support plan
- ☐ Antecedent modification implementation
- ☐ Consequence implementation
- ☐ Prompting implementation
- ☐ Reinforcement / reinforcer delivery
- ☐ Instructions to patient delivery
- ☐ Identified potential targets

FAMILY ADAPTIVE BEHAVIOR TREATMENT GUIDANCE

- ☐ Review treatment protocol
- ☐ Modeled treatment protocol for caregiver
- ☐ List directions given:

☐ **Recorded Data on Caregiver Implementation**

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During the session (face-to-face), the QHP reviews the treatment protocol with the parents, which involves the use of prompting and reinforcement to promote the individual's use of picture cards and gestures to indicate his desire to stop an activity and to request help. The QHP demonstrates those procedures with the individual while the parents observe, then has each parent in turn implement the procedures with the individual while the QHP observes, provides feedback, and records data on the individual's performance. The QHP gives the parents a copy of the treatment protocol and data sheets with instructions for implementing the protocol during typical family routines.

Federal Laws

- Mental Health Parity and Addiction Equity Act (MHPAEA)
  - https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/mhpaea_factsheet.html
- Fraud, Waste, and Abuse

(to include Federal False Claims Act, Stark Laws*, Anti-Kickback Statutes, and Anti-Trust Laws)

  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf
  - https://oig.hhs.gov/compliance/physician-education/01laws.asp
  - https://www.justice.gov/sites/default/files/civil/legacy/2011/04/22/C-FRAUDS_FCA_Primer.pdf
  - https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws
- Exclusion Database
  - https://exclusions.oig.hhs.gov/Default.aspx
- Patient Protection and Affordable Care Act
  - https://www.govinfo.gov/content/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf

State Laws and Regulations

- An Act Relative to Insurance Coverage of Autism Services (ARICA) – 2010
  - https://malegislature.gov/Laws/SessionLaws/Acts/2010/Chapter207
- Autism Omnibus Law – 2014
  - https://malegislature.gov/Laws/SessionLaws/Acts/2014/Chapter226
- Licensure of Behavior Analysts - 2015
  - https://www.mass.gov/doc/262-cmr-10-requirements-for-licensure-as-an-applied-behavior-analyst-and-assistant-applied/download
- Massachusetts Mental Health Parity
  - https://malegislature.gov/Laws/SessionLaws/Acts/2008/Chapter256
- Fraud, Waste, and Abuse (to include Federal False Claims Act, Stark Laws, Anti-Kickback Statutes, and Anti-Trust Laws)
  - https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter12/Section5A
  - https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter175H
- Massachusetts Privacy Laws
  - https://www.mass.gov/info-details/massachusetts-law-about-privacy

Resource List

- American Medical Association (AMA) Current Procedural Terminology (CPT) Book
- CPT Assistant Article
- Council of Autism Service Providers (CASP) Payer Guidelines
- Association of Professional Behavior Analysts (APBA) BACB supplement
- All links from above
- ABA Coding Coalition
- Health Care Compliance Association
- Department of Justice (DOJ)
- Health and Human Services (HHS) Office of the Inspector General (OIG)
- BACB certificant
- MA License verification
- Eligibility Verification System (MassHealth)

Upcoming AIRC Webinars

Autism Insurance in Massachusetts
March 11, 2021 7PM
Healthcare Coverage for Adults with ASD
March 16, 2021 7PM

The Autism Insurance Resource Center page on Facebook

University of Massachusetts Medical School
umassmed.edu

Questions?
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