Montana Medicaid Applied Behavior Analysis Services Manual

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Update Log

Publication History

This publication supersedes all previous Montana Medicaid Applied Behavior Analysis Services Manuals. Published by the Montana Department of Public Health & Human Services, February 2022.

Updated July 2022, September 2022, and October 2023.

Update Log

~~1~~03/01/2025

- Clarification on Intermediate professionals.
- Process for requesting information (RFI).
- Updated Additional Units of Service request and Provider Transfer Request forms.
- Added termination of services section.
- Updated language to allow usage of the most current edition of referenced materials.

10/27/2023

- Expanded definition of qualified healthcare professional with expertise in the diagnostic area

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09/23/2022

- Added definition of Intermediate Professional to Definitions and Acronyms
- Added language to Covered Services, Service Requirements that treatment plans are to be updated when clinically indicated
- Added Telehealth Exception Request to list of Forms and Documents – Required Forms

07/26/2022

- Updated age limit in Initial Eligibility section of Eligibility Chapter and SED section of Clinical Guidelines Chapter.

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02/01/2022

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End of Update Log Chapter

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Table of Contents

Key Contacts and Websites

For a list of contacts and websites see the Applied Behavior Analysis Services webpage.

For information on the certification types listed below, see the Behavior Analyst Certification Board website.

- Board Certified Behavior Analyst - Doctoral (BCBA-D)
- Board Certified Behavior Analyst (BCBA)
- Board Certified Assistant Behavior Analyst (BCaBA)
- Registered Behavior Technician (RBT)

Provider Information Website

The information below is available on the Provider Information website:

- Medicaid information and news
- Provider manuals
- Provider notices and announcements
- Fee schedules
- Forms
- Frequently asked questions (FAQs)
- Training
- Newsletters
- Key contacts
- Links to rules are on your provider type page and below:
    - Code of Federal Regulations

- Montana Code Annotated
- Administrative Rules of Montana

End of Key Contacts and Websites Chapter

Introduction

Manual Organization and Maintenance

This manual includes information for Applied Behavior Analysis Providers.

Notification of manual updates are provided through provider notices and web postings. Access the Recent Website Posts button on the bottom of the Home page of the Provider Information website.

Older versions of the manual may be found through the Archive page on the Provider Information website.

Printing the manual material found at this website for long-term use is not advisable. Department Policy material is updated periodically and it is the responsibility of the users to check that the policy they are researching or applying has the correct effective date for their circumstances.

Rule References

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. **If a manual conflicts with a rule, the rule always prevails.** ~~Paper copies of rules are available through the Secretary of State's office.~~

Claim Review (MCA 53-6-111, ARM 37.85.406)

The Department is committed to paying Medicaid providers' claims as quickly as possible. Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were billed appropriately. Although the claim processing system can detect and deny some erroneous claims, there are many erroneous claims that it cannot detect. Therefore, payment of a claim does not mean the service was correctly billed or the payment made to the provider was correct. If a claim is paid and the Department later discovers that the service was incorrectly billed or paid, or the claim was erroneous in another way, the Department is required by Federal regulation to recover any overpayment,

regardless of whether the incorrect payment was the result of the Department or provider error or other cause. (42 CFR Part 455)

End of Introduction Chapter

Definitions and Acronyms

ABA Applied Behavior Analysis
ASD Autism Spectrum Disorder
BIA Behavior Identification Assessment
BCBA Board Certified Behavior Analyst
BCBA-D Board Certified Behavior Analyst-Doctoral
BCaBA Board Certified Assistant Behavior Analyst
DD Developmental Disability
RBT Registered Behavior Technician
SED Serious Emotional Disturbance

Applied Behavior Analysis (ABA)
A type of therapy that applies human behavior principles to improve a member's adaptive functioning and reduce problem behaviors due to a psychiatric and/or behavioral condition.

Autism Spectrum Disorder (ASD)
Condition as defined in the *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM®)* of the American Psychiatric Association.

Behavior Identification Assessment (BIA)
A developmentally appropriate assessment that identifies strengths and weaknesses across domains and potential barriers to progress.

Board Certified Behavior Analyst® (BCBA®)
An individual with a graduate-level certification in behavior analysis. Professionals certified at the BCBA level are independent practitioners who provide applied behavior analysis services.

Board Certified Behavior Analyst-Doctoral® (BCBA-D®)
A BCBA who has earned their Ph.D., in addition to their master's and bachelor's degrees.

Board Certified Assistant Behavior Analyst® (BCaBA®)
An individual with an undergraduate-level certification in behavior analysis. Professionals certified at the BCaBA level provide behavior analysis services under the supervision of a BCBA.

Department, the
The Montana Department of Public Health and Human Services (DPHHS).

Developmental Disability (DD)
Disabilities defined in 53-20-202(3), MCA.

Diagnostic Evaluation
An evaluation that is performed by a qualified healthcare professional with expertise in the diagnostic area that establishes the qualifying diagnosis through interview, observation, and formal assessment tools appropriate to the condition for which services are requested. The qualified healthcare professional with expertise in the diagnostic area may use assessments from professionals outside of their fields to obtain information that contributes to the diagnostic process.

DD Eligible
A member found eligible for the receipt of state-sponsored developmental disabilities services as per ARM 37.34.201.

Eligibility Criteria
ABA services criteria the Department authorizes, which are found in this Montana Medicaid Applied Behavior Analysis Services Manual

Functional Impairment Criteria
The criteria listed and defined in the Clinical Guidelines chapter of this manual.

Intermediate Professional
A graduate student who is under the supervision of a BCBA and in process of completing or has completed basic coursework requirements for Behavior Analyst Certification Board® (BACB®) certification and is in the process of completing the experience portion of the eligibility requirements as delineated in the ~~*Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers Second Edition*~~ *Applied Behavior Analysis Practice Guidelines for the Treatment of Autism Spectrum Disorder: Guidance for Healthcare Funders, Regulatory Bodies, Service Providers, and Consumers* Third Edition issued by the ~~BACB and/or the~~ Council of Autism Service Providers.

Member
A person enrolled in Montana Medicaid who is eligible to receive those services.

Pending Authorization for Request for Information (RFI)
An authorization that is pended for a Request for Information indicates the reviewer has requested additional information from the BCBA that is necessary in order to complete the review.

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Provisional Qualifying Diagnosis
A member's diagnosis that qualifies the member for initiation of ABA services but that has not yet been confirmed by a qualified healthcare professional with expertise in the diagnostic area. The diagnosis must meet Functional Impairment Criteria and be:

a. SED; or
b. ASD; or
c. DD Eligible.

Qualified Healthcare Provider with Expertise in the Diagnostic Area
For the purposes of Montana Medicaid, ABA services refers to a licensed professional with formal training in child and adolescent psychiatric diagnosis and treatment and has training specific to SED and ASD. A qualified healthcare professional with expertise in the diagnostic area must belong to one of the following categories:

a. Child and adolescent psychiatrist;
b. General psychiatrist;
c. Psychiatric mental health nurse practitioner;
d. Developmental pediatrician;
e. Neurologist;
f. Neuropsychologist or psychologist;
g. Pediatrician;
h. Family physician;
i. Family or pediatric nurse practitioner;
j. Physician assistant;
k. Clinical professional counselor; or
l. Clinical social worker.

Qualifying Diagnosis
A member's diagnosis established by a qualified healthcare professional with expertise in the diagnostic area, through a diagnostic evaluation. The diagnosis must meet functional impairment criteria and be:

a. SED; or
b. ASD; or
c. DD Eligible.

Registered Behavior Technician (RBT)
An individual with a paraprofessional certification in behavior analysis. RBTs assist in delivering behavior analysis services and practice under the direction and close supervision of a BCBA. The supervising BCBA is responsible for all work RBTs perform.

Serious Emotional Disturbance (SED)
For the purposes of the program of ABA services authorized by the Department, an emotional disturbance as defined in the Clinical Guidelines chapter of this manual.

Technical Denial
When an adverse determination is based on procedural issues and not on medical necessity criteria, the result will be a technical denial. Technical denials can be overturned by the Department only for reasons provided for in the Administrative Rules of Montana.

Treatment Plan
An individualized written document that has been developed from the BIA and contains all the critical features listed in the *Applied Behavior Analysis Practice Guidelines for the Treatment of Autism Spectrum Disorder: Guidance for Healthcare Funders, Regulatory Bodies, Service Providers, and Consumers* Third Edition ~~*Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers Second Edition*~~ issued by the ~~Behavior Analyst Certification Board, Inc.® (BACB®) and/or~~ Council of Autism Service Providers.

Unit of Service
15 minutes of treatment service.

End of Definitions and Acronyms Chapter

Eligibility

Initial Eligibility

Montana Medicaid Applied Behavior Analysis (ABA) services administered by the Department may be provided to a member under the following required conditions:

1. The member qualifies for initial ABA services under one of the following categories:
    a. The member must have a provisional qualifying diagnosis of ASD and is no older than 20 years of age; or
    b. The member is DD Eligible and is no older than 20 years of age; or
    c. The member is a Medicaid member with a provisional qualifying diagnosis of SED and is 17 years of age or younger, **or** the member is up to 20 years of age **and** enrolled in an accredited secondary school.
2. All categories of eligibility must meet the Functional Impairment Criteria.
3. A physician, licensed mental health professional, nurse practitioner, or psychologist deemed the service medically necessary to ameliorate the symptoms of the stated provisional qualifying diagnosis. The physician, licensed mental health professional, nurse practitioner, or psychologist has documented the medically necessary service in the form of a prescription stating the diagnosis for which the member is being referred and that the referral is for ABA services.

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4. The Applied Behavior Analysis (ABA) Services Intent to Initiate Treatment form must be completed and submitted by the BCBA.

Continuing Eligibility

Any physician, licensed mental health professional, nurse practitioner, or psychologist may refer a member for the initiation of ABA services under a provisional qualifying diagnosis. However, the Department may only determine a member to be eligible for receipt of continued ABA services after the initial 180 calendar days or the initial authorized units of service are exhausted if:

1. The member continues to meet the age criteria for initial eligibility.
2. The member continues to have a provisional qualifying diagnosis that has been subsequently established as a qualifying diagnosis by a qualified healthcare professional with expertise in the diagnostic area listed below:
    a. Child and adolescent psychiatrist
    b. General psychiatrist
    c. Psychiatric mental health nurse practitioner
    d. Developmental pediatrician
    e. Neurologist
    f. Neuropsychologist or psychologist
    g. Pediatrician
    h. Family physician
    i. Family or pediatric nurse practitioner
    j. Physician assistant
    k. Clinical professional counselor
    l. Clinical social worker
3. The Department deems the member eligible through its authorization process.
4. Services continue to be deemed medically necessary by the physician, licensed mental health professional, nurse practitioner, or psychologist, and the BCBA.
5. The member continues to meet Functional Impairment Criteria, and this is supported in documentation submitted by the BCBA.

The medical necessity review and authorization process for continued eligibility and receipt of ABA services will occur every 180 calendar days or when the initial or subsequent authorized units of service are exhausted.

The Department may also review the medical necessity of services or items at any time, either before or after payment, in accordance with the provisions of ARM 37.85.410. If the Department determines that services or items were not medically necessary or otherwise in compliance with applicable requirements, the Department may deny payment or may recover any overpayment in accordance with applicable requirements.

Termination of Service

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If a provider discontinues ABA services for any reason other than a provider transfer, they must notify DDP at ddpservicerequest@mt.gov with an explanation of why services are being discontinued. This explanation should include the following information:

1. Medicaid ID
2. Prior authorization number (if applicable)
3. Date services are being discontinued.
4. End date of current eligibility span.
5. Reason services are being discontinued.
    a. Member no longer needs services.
    b. Member no longer meets eligibility (age, diagnosis, Medicaid closure, etc.).
    c. Member requested to end services.
    d. Provider is unable to deliver services.

A provider does not need to report termination of service if the provider intends to deliver services until the end date of the current eligibility span. If the current eligibility span expires and the provider takes no action to renew it, no action is required from the provider.

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End of Eligibility Chapter

Clinical Guidelines

The following clinical guidelines must be employed for each covered Montana Medicaid Applied Behavior Analysis (ABA) service:

Developmental Disability

Members with a primary Developmental Disability (DD) diagnosis must be determined eligible for services administered by the Developmental Disabilities Program. Members must also meet Functional Impairment Criteria listed in this section.

Serious Emotional Disturbance (SED)

1. Members referred for ABA services under a provisional SED diagnosis must:
    a. Have been determined by a qualified healthcare professional with expertise in the diagnostic area as having a mental disorder listed on the Serious Emotional Disturbance (SED) Diagnoses from the DSM-5 listed below; and

b. Meet the Functional Impairment Criteria requirements listed in this section; and
c. Be re-assessed annually (within 12 calendar months of the last determination) by a physician, licensed mental health professional, nurse practitioner, or psychologist. The clinical assessment must document how the member continues to meet criteria for an SED diagnosis, including specific Functional Impairment Criteria.

2. Members referred for ABA services under an SED diagnosis who continue to meet the SED criteria and who are receiving ABA services may continue to receive services if the member is **17 years of age** or younger, or the member is up to 20 years of age and enrolled in an accredited secondary school.

SED Diagnoses from the DSM-5

Neurodevelopmental Disorders

• Attention Deficit/Hyperactivity Disorder (if accompanied by another SED diagnosis)
• Other Specified Neurodevelopmental Disorder

Schizophrenia Spectrum and Other Psychotic Disorders

• Schizophreniform Disorder
• Schizophrenia
• Schizoaffective Disorder, Bipolar Type
• Schizoaffective Disorder, Depressive Type
• Other Specified Schizophrenia Spectrum and other Psychotic Disorder

Bipolar and Related Disorders

• Bipolar I Disorder
• Bipolar II Disorder
• Cyclothymic Disorder
• Other Specified Bipolar and Related Disorder

Depressive Disorders

• Disruptive Mood Dysregulation Disorder
• Major Depressive Disorder, Single Episode
• Major Depressive Disorder, Recurrent Episode
• Persistent Depressive Disorder (Dysthymia)
• Other Specified Depressive Disorder

Anxiety Disorders

• Separation Anxiety Disorder
• Panic Disorder

• Generalized Anxiety Disorder
• Other Specified Anxiety Disorder

Obsessive-Compulsive and Related Disorders

• Obsessive-Compulsive Disorder
• Hoarding Disorder
• Excoriation Disorder
• Other Specified Obsessive-Compulsive and Related Disorder

Dissociative Disorders

• Dissociative Identity Disorder
• Other Specified Dissociative Disorders

Trauma- and Stressor-Related Disorders

• Reactive Attachment Disorder
• Disinhibited Social Engagement Disorder
• Posttraumatic Stress Disorder
• Other Specified Trauma- and Stressor-Related Disorder

Somatic Symptom and Related Disorders

• Somatic Symptom Disorder
• Conversion Disorder
• Other Specified Somatic Symptom and Related Disorder

Feeding and Eating Disorders

• Anorexia Nervosa
• Bulimia Nervosa
• Binge Eating Disorder
• Other Specified Feeding or Eating Disorder

Gender Dysphoria

• Gender Dysphoria
• Other Specified Gender Dysphoria

Disruptive, Impulse-Control, and Conduct Disorders

• Oppositional Defiant Disorder
• Intermittent Explosive Disorder
• Other Specified Disruptive and Impulse-Control Disorder

Functional Impairment Criteria

Members referred for ABA services under a provisional qualifying diagnosis or subsequently established qualifying diagnosis (SED, ASD, or DD eligible) must consistently demonstrate active symptomatology which is clearly documented by the BCBA. Active symptomology means substantial impairment in functioning for at least 180 calendar days or that is reasonably predicted to last at least 180 calendar days, as manifested by two (2) or more of the following:

1. Failure to establish or maintain developmentally and culturally appropriate relationships with adult caregivers or authority figures;
2. Failure to establish or maintain developmentally and culturally appropriate peer relationships;
3. Failure to demonstrate a developmentally appropriate range and expression of emotion or mood;
4. Disruptive behavior sufficient to lead to isolation in or from school, work, home, therapeutic, or recreation settings;
5. Behavior that is seriously detrimental to the individual's growth, development, safety, or welfare, or to the safety or welfare of others; or
6. Behavior resulting in substantial documented disruption to the family including, but not limited to, adverse impact on the ability of family members to secure or maintain gainful employment.

End of Clinical Guidelines Chapter

Covered Services

General Coverage Principles

This chapter provides covered service information that applies specifically to services performed by BCBAs, BCBA-Ds, RBTs, and BCaBAs. Like all healthcare services received by Medicaid members, services rendered by these providers must also meet the general requirements listed in the Provider Requirements chapter of the General Information for Providers Manual.

Services Within Scope of Practice (ARM 37.85.401)

Services are covered only when they are within the scope of the provider's license. As a condition of participation in the Montana Medicaid program, all providers must comply with all applicable state and federal statutes, rules, and regulations.

Service Requirements

Medicaid ABA services must be deemed medically necessary and meet the eligibility criteria as established by the Department and as defined in the Eligibility Criteria chapter. Services must be directed by a BCBA or a BCBA-D. The services provided must demonstrate consistency with ABA core characteristics, Essential Practice Elements, and Assessment, Formulation of Treatment Goals, and Measurement of Client Progress as delineated in the *Applied Behavior Analysis Practice Guidelines for the Treatment of Autism Spectrum Disorder: Guidance for Healthcare Funders, Regulatory Bodies, Service Providers, and Consumers* Third Edition ~~*Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers Second Edition*~~ issued by ~~the BACB and/or~~ the Council of Autism Service Providers.

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The ABA provider must satisfy the following service requirements:

1. Complete a developmentally appropriate BIA that identifies strengths and weaknesses across domains. The assessment must also identify potential barriers to progress and have utilized multiple methods and informants, including file review, interviews and rating scales, direct assessment, and observation.
2. Develop an individualized ABA treatment plan from the BIA. The plan must contain all critical features listed in the *Applied Behavior Analysis Practice Guidelines for the Treatment of Autism Spectrum Disorder: Guidance for Healthcare Funders, Regulatory Bodies, Service Providers, and Consumers* Third Edition ~~*Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers Second Edition*~~ issued by the ~~BACB and/or the~~ Council of Autism Service Providers. The plan must include specific and quantifiable goals and be updated when clinically indicated.
3. Implement direct treatment, supervision, parent/guardian training, regular assessment of overall progress, treatment plan modification, and transition and discharge planning and document these in a manner consistent with practice guidelines and best practices.

The ABA provider must complete service requirements 1. and 2. above within 30 calendar days of the onset of services. If extenuating circumstances have precluded the completion of these service requirements within the 30 calendar-day timeframe, the BCBA directing services should submit a written clinical explanation and/or justification for the delay to the Department, with a projected date by which the service requirements will be completed. Extenuating circumstances include, but are not limited to, serious illness or family emergency.

Members who meet the above Eligibility Criteria and whose providers agree to satisfy the service requirements may use any of the following CPT codes for services within ABA treatment:

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CPT Code	Description
97151	Behavior identification assessment by professional (BCBA), each 15 minutes

97152	Behavior identification assessment by technician, each 15 minutes
97153	Adaptive behavior treatment by technician using an established plan, each 15 minutes
97154	Adaptive behavior treatment by technician with multiple patients using an established plan, each 15 minutes
97155	Adaptive behavior treatment by professional (BCBA) or intermediate professional (BCaBA) using the TC modifier using an established plan, each 15 minutes
97156	Adaptive behavior treatment by professional (BCBA) or intermediate professional (BCaBA) with family using an established plan, each 15 minutes
97157	Adaptive behavior treatment by professional (BCBA) or intermediate professional (BCaBA) with multiple family group members using an established plan, each 15 minutes
97158	Adaptive behavior treatment by professional (BCBA) or intermediate professional (BCaBA) with group using an established plan, each 15 minutes

The package of services that will be offered within the initial 180 calendar days includes 1,260 total units of service. Units of service may be utilized as the BCBA provider sees fit and within nationally accepted standards of practice. Should the member exhaust the initial package of units of service or intend to extend service delivery beyond the initial 180 calendar days, the BCBA must request additional units of service by the process defined below. Of note, unused units of service will be considered expired once the initial 180 calendar days have elapsed. Expiration of units of service does not necessarily preclude the application for additional units of service after the initial 180 calendar days. All additional units of services must be authorized before service delivery may commence. Please see the Authorization of Additional Units of Service section of this manual.

In the case of a member transitioning services to a different BCBA provider, the member's new provider must notify the Behavioral Health and Developmental Disabilities Division Program Officer. This information can be found on the Applied Behavior Analysis Services webpage.

Providers must utilize the Applied Behavior Analysis (ABA) Services Provider Transfer Request form to continue utilization of the member's authorized units of service. This information can be found in the Forms and Documents chapter in this manual.

Criteria for Additional Units of Service

The member must continue to meet the eligibility criteria and service requirements. In addition, **the following three (3) things are required:**

1. The BCBA providing services must have a reasonable expectation that the member will continue to benefit from the services and that the skill deficits and behaviors identified in the treatment plan will improve to a clinically meaningful extent.

2. The treatment plan demonstrates progress in each of the identified goals or provides a clinical explanation and modification to address a lack of progress.
3. The treatment plan demonstrates that the member is not experiencing a worsening of skill deficits or behaviors due to the treatment services.

Service Exclusion Criteria

The following criteria exclude members from being eligible for service.

1. The member demonstrates consistent worsening of skill deficits and/or behaviors with the service being delivered.
2. The member's parent/guardian is not engaged in treatment and/or does not agree to continued service delivery.
3. The member has medical conditions or impairments that would prevent beneficial utilization of services.
4. The member has demonstrated no significant progress in treatment goals for 2 consecutive additional units of service request reviews, and the BCBA provider cannot sufficiently explain the lack of progress to justify continuing to authorize the service.
5. The member can be safely and effectively treated at a less intensive level of service or care.

Concurrent Services

The Montana Medicaid Children's Mental Health Bureau (CMHB) services listed below may be provided concurrently with ABA services. For a member to have concurrent services, the ABA services must be provided and billed outside authorized treatment hours of other programs and the providers must demonstrate and document their attempts to coordinate with community-based services.

1. Partial Hospital Services (PHP)
2. Day Treatment
3. Comprehensive School and Community Treatment (CSCT)
4. Therapeutic Group Home (TGH)
5. Home Support Services (HSS)
6. Therapeutic Foster Care (TFC)
7. Extraordinary Needs Aide (ENA)
8. Targeted Case Management (TCM) for Youth with SED

The following CMHB services may not be provided concurrently for a Medicaid member that is receiving ABA services due to the duplicative nature of the services.

1. Community Based Psychiatric Rehabilitation and Support (CBPRS)
2. Psychiatric Residential Treatment Facility (PRTF)
3. Acute Inpatient Hospital Services
4. Intensive Outpatient Services (IOP)

End of Covered Services Chapter

Authorization of Additional Units of Service

The following explains the rules governing authorization of additional units of service.

Providers intending to continue to deliver services after the initial 180 calendar days or 1,260 units of service, whichever elapses first, will be required to submit for authorization. For authorization, the BCBA must complete and submit the ABA Services Additional Units of Service Request form and additional required documentation. The BCBA must submit the form and additional documentation at least 14 calendar days prior to the intended onset of continued service delivery.

Any physician, licensed mental health professional, nurse practitioner, or psychologist may refer a member for the initiation of ABA services under a provisional qualifying diagnosis. However, to be eligible for authorization of continued receipt of ABA services, the provisional qualifying diagnosis must have been established as a qualifying diagnosis through a Diagnostic Evaluation completed by a qualified healthcare professional with expertise in the diagnostic area. A qualified healthcare professional with expertise in the diagnostic area must be one of the following:

1. Child and adolescent psychiatrist
2. General psychiatrist
3. Psychiatric mental health nurse practitioner
4. Developmental pediatrician
5. Neurologist
6. Neuropsychologist or psychologist
7. Pediatrician
8. Family physician
9. Family or pediatric nurse practitioner
10. Physician assistant
11. Clinical professional counselor
12. Clinical social worker

Any additional units of services must be authorized by the Department before service delivery may begin. The Department may not give providers reimbursement retroactively for failure to submit timely, complete, and required documentation.

The process to request and the review for additional units of service is as follows:

1. For the initial request for additional units of service, the requesting BCBA completes the ABA Services Additional Units of Service Request form and submits it, the Diagnostic Evaluation, the initial Behavior Identification Assessment, and current treatment plan to the Department or other designated

reviewer at least 14 calendar days prior to the intended start of continued service delivery. Subsequent requests will require the ABA Services Additional Units of Service Request form, annual clinical re-assessment by a physician, licensed mental health professional, nurse practitioner, or psychologist (if qualifying diagnosis is SED), current BIA, and current treatment plan.

2. The reviewer examines this form and accompanying documents for completeness and adherence to the standards established in the *Applied Behavior Analysis Practice Guidelines for the Treatment of Autism Spectrum Disorder: Guidance for Healthcare Funders, Regulatory Bodies, Service Providers, and Consumers* Third Edition ~~*Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers Second Edition*~~ issued by the ~~BACB and/or the~~ Council of Autism Service Providers. **In addition, the reviewer looks for documentation to support Functional Impairment Criteria are met and clear clinical evidence supporting the need for the member to have additional units of service.**

~~3. Within 14 calendar days of receipt of the information, the reviewer will issue one of the following determinations:~~

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~~a. The information submitted is either incomplete or does not support the need for additional units of service and therefore the reviewer must deny the request. The reviewer or designee will then notify the BCBA provider of this determination in writing.~~

~~3. The information submitted supports the need for additional units of service and the reviewer must issue an approval. The reviewer or designee will then notify the BCBA provider of this determination in writing. If approved by a reviewer or designee, additional units of service may continue for 180 calendar days from the authorization date. These additional units of service may not exceed 1,260 allowable units as specified.~~ Upon receipt of the above documentation, the Department or other designated reviewer will complete the following review process:

a. A reviewer will complete the authorization review within the timelines* established by the Department or designated reviewer if the information submitted is sufficient for the reviewer to make a determination regarding medical necessity.
b. If the reviewer determines that additional information is needed to complete the review, the review is pended and the BCBA must submit the requested information within the timelines* established by the Department or designated reviewer. If the requested information is not received within this time frame, the reviewer will issue a technical denial.
c. Upon receipt of additional information requested, the reviewer will complete the authorization review within the timelines* established by the Department or designated reviewer.

d. The reviewer will authorize the additional units of service request and generate notification to all relevant parties if medical necessity criteria are met.
e. The reviewer will deny the additional units of service request and generate notification to all relevant parties if medical necessity criteria are not met.

f. If approved by a reviewer or designee, additional units of service may continue for 180 calendar days from the authorization date. These additional units of service may not exceed 1,260 allowable units as specified.

~~b.~~g. *BCBA's may locate the timelines referenced above in the Behavioral Health Provider User Guide for Montana Medicaid Behavioral Health Services Submitted through Qualtrac Effective Autust, 2024, 2021. This may located at the following link: https://mountainpacificfiles.blob.core.windows.net/content/dlm_uploads/2024/10/Qualitrac-BH-Provider-User-Guide_revised-08.13.24-508.pdf.

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~~A service provider may resubmit a request for additional units for service if they have additional information which would satisfy the deficiencies noted on the previous denial. It is important to note that this will be considered a new submission and all required documents will need to be submitted for review and determination.~~

A member may appeal the reviewer's or designee's determination. To appeal a determination outcome, a member or representative for the member may request an Administrative Review. For information regarding Administrative Reviews and Fair Hearings, please see the Administrative Reviews and Fair Hearings section in the General Information for Providers Manual.

For general information about authorization, see the Prior Authorization chapter in the General Information for Providers Manual.

End of Authorization of Additional Units of Service Chapter

Forms and Documents

Required Forms

Forms, including those listed below, are available on the Applied Behavior Analysis Services page of the Montana Healthcare Programs Provider Information website.

- Intent to Initiate Treatment
- Additional Units of Service Request

- Required Document Components Checklist (applies to Additional Units of Service Requests only)
- Provider Transfer Request
- Telehealth Exception Request (applies when requesting service delivery via telehealth)

Required Documents

(applies to Additional Units of Service Requests only)

- Diagnostic Evaluation
- Behavior Identification Assessment
- Current Treatment Plan
- Clinical Re-Assessment (required annually and applies only to SED)

Optional Documents

- Functional Behavior Assessment
- Positive Behavior Support Plan
- Progress Notes
- Family and/or Collaboration Notes

End of Forms and Documents Chapter

Billing Procedures

Services provided by a BCBA covered in this manual must be either electronically billed or on a CMS-1500 claim form. CMS-1500 claim forms are available from various publishing companies and are not available from the Department or Provider Relations.

Cost Sharing

Members receiving ABA services are exempt from cost sharing.

Members with Other Insurance

If a member has additional insurance coverage, including Medicare, or a third party has responsibility for the member's healthcare costs, please see the Members Eligibility and Responsibilities chapter in the General Information for Providers Manual.

Using the Medicaid Fee Schedule

Providers billing Medicaid should use the Department's fee schedule, designated by provider type, as well as the detailed coding descriptions listed in the CPT and Healthcare Common Procedure Coding System (HCPCS) coding books. Current fee schedules are available on the Applied Behavior Analysis Services page on the Provider Information website.

The BCBA assumes full professional responsibility for all services provided by a BCaBA or RBT. All services are billed under the BCBA's National Provider Identifier (NPI). Providers bill using standard Current Procedural Terminology (CPT) procedure codes and are reimbursed according to the Department's Resource-Based Relative Value Scale (RBRVS) system.

End of Billing Procedures Chapter

How Payment is Calculated

Overview

Though providers do not need the information in this chapter to submit claims to the Department, the information allows providers to understand how payment is calculated and to predict approximate payment for claims.

The RBRVS Fee Schedule

Most services by provider types covered in this manual are reimbursed for using the Department's RBRVS fee schedule. The fee schedule includes CPT codes and Healthcare Common Procedure Coding System (HCPCS) codes. Within the CPT coding structure, only anesthesia services and clinical lab services are not reimbursed for using the RBRVS fee schedule.

RBRVS was developed for the Medicare program. Medicare does a major update annually, with smaller updates performed quarterly. Montana Medicaid's RBRVS-based fee schedule is based largely on the Medicare model, with a few differences as described below. By adapting the Medicare model to the needs of the Montana Medicaid program, the Department was able to take advantage of the research performed by the federal government and national associations of physicians and other healthcare professionals. RBRVS-based payment methods are widely used across the United States by Medicaid programs, workers' compensation plans, and commercial insurers.

Fee Calculation

Each fee is the product of a relative value times a conversion factor.

Basis of Relative Values

For almost all services, Medicaid uses the same relative values as Medicare in Montana. Nationally, Medicare adjusts the relative values for differences in practice costs between localities, but Montana is considered a single locality. For less than 1% of codes, relative values are not available from Medicare. For these codes, the Department has set the relative values.

Conversion Factor

The Department sets the conversion factor for the state fiscal year (July through June) and it is listed on the fee schedule.

End of How Payment is Calculated Chapter

Search Options

This manual has 3 search options.

1. **Search the whole manual.** Open the Complete Manual pane. From your keyboard press the Ctrl and F keys at the same time. A search box will appear. Type in a descriptive or key word (for example "Denials"). The search box will show all locations where denials discussed in the manual.
2. **Search by Chapter.** Open any Chapter tab (for example the "Billing Procedures" tab). From your keyboard press the Ctrl and F keys at the same time. A search box will appear. Type in a descriptive or key word (for example "Denials"). The search box will show where denials discussed in just that chapter.
3. **Site Search.** Search the manual as well as other documents related to a particular search term on the Montana Healthcare Programs Site Specific Search page.

End of Search Options Chapter

End of Montana Medicaid Applied Behavior Analysis Services Manual