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MEDICAID BULLETIN

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Applied Behavior Analysis (ABA) Policy and Regulatory Clarifications

The purpose of this bulletin is to remind, clarify, and reinforce the following existing policies and regulations regarding Applied Behavior Analysis (ABA) services. The Department of Medical Assistance Services (DMAS) has been made aware of actions that are not in compliance with existing ABA rules and regulations and not aligned with the expectations of Medicaid providers of ABA services. DMAS reminds providers that any actions that are out of compliance with rules and regulations may result in negative consequences, including retraction of Medicaid payments. Topic areas of concern include:

1. Services provided in a clinic or office setting without documented clinical justification for the location in the Individual Service Plan (ISP) are not covered.

2. Service authorization requests for more than 20 hours per week require significant detailed documentation and justification.

3. Only Licensed Behavioral Analysts (LBAs), Licensed Assistant Behavioral Analysts (LABAs), and Licensed Clinical Psychologists have delegation authority for non-licensed staff to deliver ABA services under their supervision. Other licensed mental health professionals (LMHPs) including Licensed Clinical Social Workers (LCSWs) and Licensed Professional Counselors (LPCs) and LMHP residents/supervisees do not have delegation authority in ABA and cannot supervise the delivery of ABA services by non-licensed staff.

4. Initial assessments must be conducted in person by an LBA, LABA or LMHP in order for ABA services to be reimbursable by Medicaid.

5. Service authorization requests for ABA services provided through telemedicine require detailed documentation and justification.

In order to qualify for reimbursement, all service delivery must meet the licensed clinician’s scope of practice guidelines and must meet the DMAS program rules as defined in program manuals and regulations.

Clinic-Based/Center-Based ABA Services Must be Justified

If services are to be provided in a clinic/office or center-based setting, documented justification for the location shall be provided in the ISP and authorized by DMAS service authorization contractors (Acentra Health and Cardinal Care Managed Care Organizations). Services should only be provided in a clinic/office/center-based setting when a specific clinic/office/center-based setting is medically necessary, and the justification of clinical need or therapeutic rationale is clearly documented in the ISP. In addition, requests for continued service authorizations must include "a summary of progress towards generalization of adaptive functioning in multiple settings to include assessing for maintenance of the skills acquired and updating the ISP as needed to test for generalization of skills in multiple environments" (Appendix D of the Mental Health Services Manual, page 29).

Services shall only be reimbursed when in compliance with the Mental Health Services Manual, which indicates in Chapter IV that the following shall not be covered under Mental Health Services, including ABA:

1. Services rendered that are not in accordance with an approved service authorization.

2. Services not identified on the individual's authorized ISP or treatment plan. This includes services that are provided in a clinic or provider's office without documented justification for the location in the ISP.

3. Time spent in any activity that is not a covered service component (examples include, but are not limited to: childcare, respite care, housing, time spent in transportation, or snacks and meals unless clinically indicated via assessment).

When services are provided in a clinic/office/center-based setting, caregiver involvement requirements shall apply and family involvement and training is required throughout treatment. These requirements include:

1. Direct family involvement in the treatment program is required at a minimum of weekly and must be documented in the ISP. Family involvement includes, but is not limited to, assessment, family training, family observation during treatment, updating family members on the youth's progress and involving the family in updating treatment goals.

2. Family training (97156, 97157) is required. Family training involving the youth's family and significant others shall:

a. be for the direct benefit of the youth and not for the treatment needs of the youth's family or significant others;

b. occur with the youth present except when it is clinically appropriate for the youth to be absent in order to advance the youth's treatment goals; and,

c. be aligned with the goals of the youth's ISP.

Service authorization contractors are authorized and expected to require sufficient documentation for all of these components. Providers shall be required to maintain documentation detailing all relevant information about the Medicaid individuals who are in the provider's care. Such documentation shall fully disclose the extent of services provided and the medical necessity for the service in order to support requests for service authorization and the provider's claims for reimbursement for services rendered.

Additional Documentation is Required for Service Authorization Requests over 20 Hours Per Week

Documentation shall also clearly justify requests exceeding over 20 hours per week. Per Appendix D, page 28 of the Mental Health Services Provider Manual, providers shall submit "for all requests exceeding 20 hours (80 units) or more per week, the schedule of activities used to structure the service sessions and describe how the activity will facilitate the implementation of the ABA treatment. Each session must clearly be related to the successful attainment of the treatment goals. The therapeutic function of all scheduled sessions must be clearly defined regarding the number of hours requested. Schedules must be individualized. A general schedule of clinic-based activities is not sufficient to meet this requirement. Clinic-based schedules must also distinguish between time the individual spends in therapeutic interventions and time spent in recreational and non-therapeutic activities**".** For example, any activities not addressing specific goals in the treatment plan, such as napping or eating meals unrelated to specific treatment goals would all be examples of time spent in non-therapeutic activities.

Documentation must support the need for the service, detailed description of individualized interventions that support the number of hours requested and justification for the location when services are provided in a clinic or office setting. Time spent in sessions that are conducted for family support, education, recreational or custodial purposes, including respite or child care are not covered.

Only Certain LMHPs have Delegation Authority to Non-Licensed Staff; LMHPs Must be Acting within Scope of Practice

For all services, LMHPs must practice within their specific scope of practice, defined by their

individual license type.

1. Licensed Behavioral Analysts (LBAs), Licensed Assistant Behavioral Analysts (LABAs), and Licensed Clinical Psychologists have delegation authority for non-licensed staff to deliver ABA services under their supervision.

2. LMHPs that are not LBAs, LABAs, or Licensed Clinical Psychologists (e.g., Licensed Clinical Social Workers, Licensed Professional Counselors) do NOT have delegation authority; they cannot oversee non-licensed staff delivering ABA under their supervision. They can provide ABA directly or supervise services provided by LMHP residents/supervisees in accordance with the applicable Virginia Health Regulatory Board, if they have appropriate training in ABA.

3. LMHP residents/supervisees shall not supervise ABA services.

Technician level services provided by staff who do not meet one of the below criteria are not reimbursable to Medicaid and subject to retraction. Per the Mental Health Services Manual, Appendix D, page 30:

“CPT codes for services provided by a technician must be provided by one of the following: a) An LMHP-R, LMHP-RP or LMHP-S under supervision as defined by the applicable Virginia Health Regulatory Board b) An LABA under the supervision of a LBA c) Personnel under the supervision of a LBA or LABA in accordance with 18VAC85-150-10 et seq. of the Virginia Board of Medicine regulations. d) Personnel under the supervision of a Licensed Clinical Psychologist in accordance with §54.1-3614. e) An LBA or LMHP acting as the technician.”

Initial Assessments Must be Conducted In Person

Per the Mental Health Services Manual, Appendix D, page 22:

- An initial assessment for ABA consistent with the components required in the Comprehensive Needs Assessment (see Chapter IV for requirements), documenting the youth's diagnosis/es and describing how service needs match the level of care criteria must be completed at the start of services. In addition, the initial assessment must:
    - be completed by the LBA, LABA or LMHP acting within the scope of practice. Other qualified staff may assist with the completion of an assessment (see staff requirements section);

- be conducted in-person with the youth and the youth's family/caregivers;
- include a functional assessment using validated tools completed by the LBA, LABA or LMHP acting within the scope of practice.
- Assessments must be reviewed and updated at least annually by the LBA, LABA or LMHP.

Services will not be reimbursed if the assessment is incomplete, outdated, or missing. Additionally, services provided based on an assessment that does not meet DMAS assessment requirements for the service are non-reimbursable by Medicaid.

Additional Documentation is Required for Services Provided Through Telemedicine

While the use of telemedicine can greatly expand access to services, it is important to note that ABA services provided through a telemedicine service delivery model will not be appropriate for all youth. ABA providers must document that the youth and their parent/caregiver have the skills required to participate in a meaningful, safe way during telemedicine delivered services.

When services are provided through telemedicine, providers must follow the requirements contained in the Telehealth Services Supplement to the Mental Health Services Manual. In addition, if services are provided through telemedicine, the ISP must include, at a minimum, the following:

1. A schedule that includes when or under which conditions services will be provided through telemedicine and when services are scheduled to be provided in-person.
2. Clinical evidence that the amount, duration and scope of the use of telemedicine is a clinically appropriate modality to meet the treatment needs of the individual.
3. Evidence of how a provider will meet the identified treatment needs documented in the ISP via an in-person modality, when needed.

All providers are directed to review their policies and procedures and ensure that they are providing ABA services in accordance with DMAS policy. DMAS and its contractors shall ensure that services are authorized and reimbursed in accordance with DMAS policy and service authorization and program integrity processes shall incorporate these clarifications in the review of services requested and rendered.

Questions related to ABA service policy can be sent to the Behavioral Health Division at enhancedbh@dmas.virginia.gov

To avoid disruption to claims payment through FFS and the MCOs providers must periodically check the DMAS provider portal, also known as the Provider Services Solution (PRSS), to ensure that the provider's enrollment, contact information, and license information is up to date, for all of the provider's respective service locations. Under federal rules, MCOs and DMAS are prohibited from paying claims to network providers who are not enrolled in PRSS. Additional information is provided on the MCO Provider Network Resources webpage and includes links to resources, tutorials and contact information to reach Gainwell with any provider enrollment or revalidation related questions. Dental providers should continue to enroll directly through the DMAS Dental Benefits Administrator, DentaQuest.

PROVIDER CONTACT INFORMATION & RESOURCES

Virginia Medicaid Web Portal **Automated Response System (ARS)** Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	https://vamedicaid.dmas.virginia.gov/
Medicall (Audio Response System) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	1-800-884-9730 or 1-800-772-9996
Provider Appeals DMAS launched an appeals portal in 2021. You can use this portal to file appeals and track the status of your appeals. Visit the website listed for appeal resources and to register for the portal.	https://www.dmas.virginia.gov/appeals/

Managed Care Programs

Cardinal Care Managed Care and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different guidelines than those described for Medicaid fee-for-service individuals.

Cardinal Care Managed Care	https://www.dmas.virginia.gov/for-providers/managed-care/cardinal-care-managed-care/
PACE	Program of All-inclusive Care (virginia.gov)
Provider Enrollment	In-State: 804-270-5105 Out of State Toll Free: 888-829-5373 Email: VAMedicaidProviderEnrollment@gainwelltechnologies.com

Provider HELPLINE Monday–Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available.	1-804-786-6273 1-800-552-8627
Aetna Better Health of Virginia	https://www.aetnabetterhealth.com/virginia/providers/index.html 1-800-279-1878
Anthem HealthKeepers Plus	http://www.anthem.com/ 1-800-901-0020
Humana Healthy Horizons Provider Services Call Center	1-844-881-4482 (TTY: 711) https://provider.humana.com/medicaid/virginia-medicaid
Sentara Community Plan	1-800-881-2166 https://www.sentarahealthplans.com/providers
United Healthcare	www.uhcprovider.com/ 1-844-284-0146
Acentra Health Behavioral Health and Medical Service Authorizations	https://vamedicaid.dmas.virginia.gov/sa 1-804-622-8900
Dental Provider DentaQuest	1-888-912-3456
Fee-for-Service (POS) Prime Therapeutics	https://www.virginiamedicaidpharmacyservices.com/ 1-800-932-6648