Vermont Medicaid
Applied Behavior Analysis Supplement

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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Section 1 Introduction

This manual is designed as a supplement to and does not replace the **Vermont Medicaid General Provider Manual** which can be found at http://www.vtmedicaid.com/#/manuals.

This supplement describes processes to be followed by Vermont Medicaid enrolled providers of Applied Behavioral Analysis services and the Department of Vermont Health Access (DVHA) when Vermont Medicaid members receive Applied Behavior Analysis (ABA) services.

Vermont Medicaid only pays for healthcare services that are medically necessary. Per Medicaid Rule, 7103, medically necessary is defined as healthcare services that are appropriate, in terms of type, amount, frequency, level, setting and duration to the member's diagnosis or condition and must conform to generally accepted practice parameters recognized by health care providers in the same or similar general specialty who typically treat or manage the diagnosis or condition.

As defined in Act 158, "applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior. The term includes direct observation, measurement, and functional analysis of the relationship between environment and behavior. ABA includes a wide variety of evidence-based strategies to impact behavior.

1.1 Applied Behavior Analysis Services

Vermont Act 158 (8 V.S.A. § 4088i.), an act relating to health insurance coverage for early childhood developmental disorders, including autism spectrum disorders (ASD), was passed May 16, 2012. Act 158 requires private and Vermont Medicaid insurance plans to cover medically necessary, evidence-based diagnosis and treatment of autism spectrum disorders, including applied behavioral analysis supervised by nationally board-certified behavior analysts, for children birth until the age of 21 years.

Vermont Medicaid began enrolling Board-Certified Behavior Analysts (BCBA) and Board-Certified assistant Behavior Analysts (BCaBA) in June of 2015 and the ABA benefit became effective July 1, 2015.

1.2 Utilization Management

The DVHA conducts numerous utilization management and review activities to ensure that quality services, those which increase the likelihood of desired health outcomes and are consistent with prevailing professionally recognized standards of medical practice, are provided to members and that providers are using the program appropriately, effectively, and efficiently. DVHA utilizes clinical criteria for making utilization review decisions that are objective and based on sound medical evidence. Approved criteria for the services in this supplement include the following:

- Change Healthcare, LLC InterQual® Criteria*
- DVHA Clinical Guidelines: https://dvha.vermont.gov/providers/clinical-practice-guidelines
- Vermont State Medicaid Rules: https://humanservices.vermont.gov/rules-policies

*Change Healthcare, LLC InterQual® Guidelines are available to providers on the Vermont Medicaid website http://www.vtmedicaid.com/#/home and navigating to the **Transactions** Menu and choosing the **Login** option. After log-in, look for the link Change Healthcare Smart Sheets in Secure Options drop-down menu. InterQual® Guidelines are updated annually.

1.3 Coverage Review

The Department of Vermont Health Access (DVHA) conducts code reviews on a quarterly or annual basis depending on the type of services that are being requested for consideration. This means that a newly released procedure code may not be available until the next quarterly or annual code review as applicable to the type of specific procedure code.

For additional information, please see the General Billing and Forms Manual.

1.4 Court Ordered Services

If a member is mandated to seek a service, the service may be covered if it meets the medical necessity and Vermont Medicaid guidelines.

For additional information, please see the General Billing and Forms Manual.

1.5 Retrospective Review

The DVHA will not perform retrospective reviews for the purpose of reviewing authorization decisions and recoupment of payments except in the case of material misrepresentation or fraud.

Section 2 Applied Behavior Analysis Benefit Provider Guidance

Vermont Medicaid covers medically necessary, evidence-based diagnosis and treatment of autism spectrum disorders, including applied behavioral analysis (ABA) supervised by nationally board-certified behavior analysts, for children birth until the age of 21 years. Vermont Medicaid pays for ABA using two separate funding methodologies depending on insurance status; Case Rate for individuals with only Medicaid as their sole insurance, and fee-for-service for individuals who have other insurance coverage in addition to Medicaid.

All ABA services (regardless of payment methodology) must be medically necessary. The same documentation standards apply to both funding methodologies, and clinical best practice is expected. The Case Rate requires monthly submission of a Tier Request Form to identify tiers. This form will be provided by the DVHA once services are established. Fee-for-service requires prior authorization.

When Medicaid is not primary and services are denied by the primary insurance, the provider and/or member is required to pursue all levels of reconsideration and appeals with the primary insurer. If the request remains denied by the primary insurer, the provider and/or member is required to seek review by the Vermont Department of Financial Regulation if the cost of the item or service exceeds $100. If the denial stands, then the provider may submit the request to the DVHA with copies of all the original documentation, the denials from the primary insurer and the Department of Financial Regulation's support of the denial. The provider should not submit any additional documentation other than what was reviewed by the primary insurer. If the code/service does not require authorization from Vermont Medicaid, then the provider may bill Vermont Medicaid directly, with copies of the primary insurer's denials (original and appeals) and the Department of Financial Regulation's support of the denial attached.

ABA forms can be found at https://dvha.vermont.gov/forms-manuals/forms/clinical-prior-authorization-forms.

Information outlined in the ABA Administrative Rule and ABA Clinical Guidelines will not be repeated in this provider manual. Providers can access the ABA Administrative rule at https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/GCRProposedPolicies/aba-policy-final.pdf and the Clinical Guidelines at https://dvha.vermont.gov/providers/clinical-practice-guidelines.

2.1 Provider Requirements

Board Certified Behavior Analysts (BCBAs) must be enrolled as a Vermont Medicaid provider. More information on how to enroll with Vermont Medicaid can be found at http://vtmedicaid.com/#/provEnrollDataMaint.

Board Certified Behavior Analysts (BCBAs), Board Certified Assistant Behavior Analysts (BCaBAs), and Behavior Technicians (BTs), providing ABA services must have an approved background check in their personnel file that includes:

- For those that have been a Vermont resident for more than five years, a Vermont criminal record check obtained through the Vermont Criminal Information Center (VCIC) that includes the sex offender registry, or

- For those that are not a Vermont resident or have been for less than five years, a national criminal record check obtained from the Federal Bureau of Investigations (FBI) through the national criminal record check, and
- Vermont Abuse Registry checks (both Child Abuse Registry and Adult Abuse Registry).

BTs providing ABA services must have documentation of completing all the following trainings prior to providing services:

- At least 40 hours of training in the implementation of ABA to include a minimum of three hours of ASD-specific training and minimum of three hours of ethics and professional conduct specific training,
- Current First Aid Certification renewed at least every three years,
- Universal Precautions,
- Current Cardiopulmonary Resuscitation (CPR) Certification renewed annually,
- Confidentiality and HIPAA compliance, and
- AHS Mandated Reporter.

2.2 Documentation Requirements

DVHA requires documentation for every member receiving ABA services and must be included in the member's file:

- Clinical documentation includes all the following:
    - State of Vermont Uniform Medical Prior Authorization form (for Medicaid as secondary only. See section 2 above.),
    - Prescription for ABA services,
    - Current diagnostic assessment (DVHA may request a reassessment be provided if medically necessary and additional services are being requested),
        - The diagnostic assessment should utilize autism diagnostic tool(s) and must be administered by a qualified professional including: a board certified or board eligible psychiatrist, doctorate-level licensed psychologist, a board certified or board eligible neurologist, a developmental-behavioral or neurodevelopmental disabilities pediatrician, or a masters-level licensed clinician experienced in the diagnosis and treatment of autism.
    - An assessment by a BCBA recommending ABA specific treatment,
        - Assessment should include: direct observation of the member, interview with the member, parent(s)/guardian(s), caregiver(s), teacher(s), and to the extent possible other professionals involved in the member's care (e.g., speech and language pathologist, therapist, and occupational therapist); file review; administration of behavior scales or other assessment tools; and integration of existing information to establish current functioning across domains including language/communication, motor, cognitive, social/emotional and adaptive behavior.

- ABA treatment plan specific to the member that includes:
    - Measurable treatment goals, objectives, and outcomes,
    - Incorporation of assessment tools used,
    - Direct and non-direct observation, and
    - List of staff members and their credentialing who will be working directly with the member.
- One of the following assessment tools is required at a minimum of every six months (other assessment tools may be used if clinically appropriate but may not be substituted. If the provider determines that none of the below-mentioned authorized assessment tools are not clinically indicated for a member, they should notify the DVHA Autism Specialist and document clinical rationale. Rationale should explain if one of the above clinical tools was attempted, and why it was unsuccessful. Clinical rationale should be determined on a member-by-member basis. It should not be due to the fact the provider does not have access to these assessment tools or because the provider is not trained in the administration of the tools. Please refer to the ABA Clinical Practice Guidelines https://dvha.vermont.gov/providers/clinical-practice-guidelines:
  - Promoting the Emergence of Advanced Knowledge (PEAK),
  - Verbal Behavior Milestone Assessment and Placement Program (VB-MAPP),
  - Early Start Denver Model (ESDM).
- Progress notes; a minimum of one per month.
- DVHA may require more clinical information and or documentation upon request.

DVHA uses evidence-based criteria to make authorization decisions and notifies providers within three business days of receiving all necessary information.

2.3 Case Rate Specific Requirements – Medicaid ONLY Members

Case Rate will be utilized for all members with an ASD diagnosis or an early childhood developmental disability disorder who have Medicaid only coverage.

1. **Submission:** Tier Request Form submissions ensure tier assignments reflect actual treatment hours provided for the previous month. Providers must submit the tier request form via GlobalScape to the DVHA Autism Specialist or designee by the last business day prior to the 15th of the month to determine tier assignment based on clinically recommended treatment hours.

   The following information must be provided in the tier submission form:

   - Member's name,
   - UID,
   - DOB,
   - Reported Hours,
   - Reported Tier,

- Reason for chosen tiers/hours,

Tier requests can be submitted as frequently as monthly. Providers must contact the DVHA Autism Specialist or designee via e-mail AHS.DVHAABABenefit@vermont.gov for any tier related questions.

Services for members with an early childhood developmental disability diagnosis (non ASD diagnosis) require clinical review prior to implementation of service. The DVHA Autism Specialist or designee determines eligibility after a thorough review of a member's clinical documentation.

2. **Case Rate Tiers:** The case rate is comprised of 14 tiers and is based on the number of anticipated service hours:

Tier	Hours
0	0
1	2-5
2	6-14
3	15-24
4	25 – 34
5	35 – 49
6	50 – 64
7	65 – 79
8	80 – 94
9	95 – 109
10	110 – 124
11	125 – 139
12	140 – 154
13	155 – 169
14	170 +

Included codes - The following CPT codes are included in monthly totals:

- **Assessment codes*:**
  - 97151
  - 97152
  - 0362T**
- **Treatment codes:**
  - 97153
  - 97154
  - 97158

- 0373T**

- **Program Supervision*:**
  - 97155
- **Parent Training:**
  - 97156
  - 97157
- **Team Conference*:**
  - 99366
  - 99368

** Adherence to code restrictions is expected. Any exceptions must have supporting clinical documentation demonstrating medical necessity and should be discussed with DVHA Autism Specialist.*

*** Providers should only multiply claim hours by two (for codes 0373T and 0362T) when SELECTING a monthly tier.*

3. **Assessments and Reassessments:** Assessment and reassessment hours will be included in the monthly total hours for tier assignments in the month they are administered. Providers should notify the DVHA Autism Specialist or designee if any assessments were completed that were not included in a tier assignment.

   Assessment code limitations are as follows:

   a. 97151 – Limited to 4 BCBA hours every 6 months
   b. 97152 – Limited to 4 BT hours every 6 months
   c. 0362T – Limited to 4 BT hours every 6 months

4. **Shadow Claims:** While payment for services provided is no longer dependent on submitted claims, providers are expected to continue to submit "shadow" claims for purposes of data collection and reconciliation. Shadow claims are submitted in the same way as regular claims except they are zero-paid. Shadow claims must be submitted after providers receive the case rate payment for the given month. Payment schedules follow the annual Management and Reporting System (MARS) calendar that is disseminated to all providers by the Autism Specialist or designee. Otherwise, shadow claims will either pay FFS, deny, or suspend affecting the yearly reconciliation. It is important for providers to submit claims in a timely manner, including those case rate member claims that will be zero paid because of the monthly case rate payment. It is recommended that providers submit claims at least monthly. **Claims are required to be submitted within 6 months of service.** In addition, claims that are denied must be corrected and resubmitted **within 6 months of the initial denial.** Please refer to section 3.3 of the Vermont Medicaid Provider Manual (vtmedicaid.com) for detailed information on timely filing.

5. **Monitoring:** DVHA will conduct annual mid-year reviews to compare shadow claims with tier placement. The expectation is the hours provided, through shadow claims submission, match the reported tier. The Autism Specialist will provide individualized mid-year reconciliation

letters that include the monthly claim status breakdown. Providers are required to review Remittance Advices in order to track submitted claims to ensure awareness regarding suspended/denied/accepted claims. Providers may request a meeting with the Autism Specialist. Additionally, the Autism Specialist will reach out individually to providers with outliers or if there are concerns with claim level data trends. Questions regarding specific claims should be referred to your Provider Representative. http://www.vtmedicaid.com/assets/resources/ProviderRepMap.pdf.

6. **Site Visits:** The DVHA Autism Specialist or designee will conduct annual virtual site visits, typically scheduled in advance but may be unannounced. Providers may also request a site visit by DVHA staff. During virtual site visits, the DVHA Autism Specialist or designee will initially meet with the providers via Microsoft Teams before reviewing all or a representative sample of member files. There are no specific requirements for the organization of charts (paper, electronic, etc.). However, documentation should demonstrate adherence to clinical best practices. See above section 2.2 for documentation that should be included within member files.
7. **Reimbursement:** Once tier request forms have been submitted highlighting the reported tier for each member, providers will receive post service delivery payment. Providers will receive one payment that includes the tier rates for all Medicaid members they are providing services to. Payments will be issued the last Friday of every month. A tier request form will be provided monthly.
8. **Reconciliation:** Reconciliation will occur annually for each calendar year (January 1st to December 31st). Reconciliation for the previous year will begin in July, using the Medicaid Management Information System (MMIS) as the data source for all claims used for the reconciliation, and will be based on the complete data set as of June 30th.

   Reconciliation will happen at the provider level, and all billed hours will be subject to review during the reconciliation process. All ABA services (allowable under the case rate) will be totaled for each month to determine the Final Monthly Tier. DVHA will review the Final Monthly Tier against the Provider-Selected Monthly Tier for each member for each month of service. Months will be aggregated to reconcile the total year-end difference for each member. Member differences will be aggregated to determine the total net loss or gain for the provider. Reconciliation will be to 100% of the difference.

   Calculations will be based on the following:

CPT Code	Tier Calculation	Claims Hours
97151	Total Billable Monthly Hours	Hours
97152	Total Billable Monthly Hours	Hours
97153	Total Billable Monthly Hours	Hours
97154	Total Billable Monthly Hours	Hours
97155	Total Billable Monthly Hours	Hours
97156	Total Billable Monthly Hours	Hours
97157	Total Billable Monthly Hours	Hours

97158	Total Billable Monthly Hours	Hours
99366	Total Billable Monthly Hours	Hours
99368	Total Billable Monthly Hours	Hours
0362T[++]	Total Billable Monthly Hours	Hours * 2
0373T[++]	Total Billable Monthly Hours	Hours * 2

[++] DVHA will account for the two-on-one codes (0362T and 0373T) by multiplying hours by two.

Providers should not multiply claims hours by two when submitting shadow claims.

9. **Communication with DVHA:** All ABA providers have been given access to an agency specific file in GlobalScape, a HIPAA compliant platform in which providers will share clinical documentation with DVHA.

   If you have any questions or concerns regarding the Vermont Medicaid ABA benefit, please email AHS.DVHAABABenefit@vermont.gov.

2.4 Fee-For-Service Requirements – Members who have other insurance

Providers will follow fee-for-service requirements for members when Medicaid is not the primary insurance.

If the primary insurance does not cover any or all ABA service claims, Medicaid may cover the service if determined clinically appropriate (requires prior authorization by DVHA). The provider must submit the primary insurance denial letter with the request. It is important to note that VT Medicaid is the payor of last resort.

1. **Prior Authorization:** Prior Authorization is required when Medicaid is the secondary insurer. The State of Vermont Uniform Medical Prior Authorization Form can be found at https://dvha.vermont.gov/forms-manuals/forms/clinical-prior-authorization-forms. The PA must be faxed to DVHA 855.275.1212 and authorized prior to service delivery.

   DVHA uses evidence-based criteria to make authorization decisions and notifies providers within three business days of receiving all necessary information.

2. **Continued Clinical Authorization:** Continued Clinical Authorizations must be submitted to DVHA every six months (unless greater frequency is clinically indicated). Please refer to the required documentation in section 2.2 above. **Required documentation must be faxed to DVHA 855.275.1212 and authorized prior to service delivery.**

3. **Reimbursement:** Providers will be reimbursed Fee for Service for claims submitted for services rendered, as authorized by DVHA.

4. **ABA Procedures for Billing:** Providers should use appropriate modifiers based on who delivers treatment services. Using the HO/HN modifier determines the correct reimbursement rate percentage on fee-for-service (FFS) claims. Modifiers should be utilized for both case rate shadow claims and FFS claims. Accurate claim submission ensures correct reimbursement rates.

If additional support is needed, providers should reach out to their assigned Provider Representative http://vtmedicaid.com/assets/resources/ProviderRepMap.pdf.

Provider Rendering Services	Modifier	Reimbursement for FFS Claims
Board Certified Behavior Analyst (BCBA) means a treatment provider who holds a master's degree and is certified through the National Behavior Analyst Certification Board (BACB).	HO indicates master's level degree	76% of Vermont Medicaid rate on file.
Board Certified assistant Behavior Analyst (BCaBA) means a treatment provider who holds a minimum of a bachelor's degree, is certified through the BACB, and is directly supervised by a BCBA.	HN indicates bachelor's level degree	66% of Vermont Medicaid Rate on File.

Section 3 Policy References

4.101 Medical Necessity

7102.2 Prior Authorization Determination

3.101 Telehealth

9.103 Supervised Billing

Medicaid Rules

Office of Professional Regulation

ABA Clinical Practice Guidelines

Section 4 Reconsideration Process

The DVHA will conduct a review of a denied service at the request of a provider. The DVHA will conduct the following types of reviews:

- Prior Authorization denial by the DVHA at the request of a provider (when Medicaid is secondary),
- Clinical Review denial by the DVHA,
- Peer to Peer review with the DVHA Physician,

The DVHA will not review any decision other than those listed above. All requests for the above reconsiderations must be faxed to 802.879.5963.

For additional information, please see the General Billing and Forms Manual.

4.1 Determination Time

Determination timeframes now correspond to 42 CFR §438.210. DVHA will continue to issue a notice of decision within 3 business days of receipt of all the necessary information. However, the longest time to wait for a decision is now 28 days, not 30. A request must be decided within 14 calendar days of receipt of the request, but that timeframe may be extended up to another 14 calendar days if the member or provider request the extension, or if the extension is needed to obtain additional information and an extension is in the member's interest.

Also, when a provider indicates, or DVHA determines, that following this timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, DVHA must make an expedited decision and provide notice as expeditiously as the member's health condition requires and no later than 3 business days after receipt of the request. This may be extended up to 14 calendar days if the member so requests, or if the extension is needed to obtain additional information and an extension is in the member's interest. Under federal law, the department is obligated to provide a response within 24 hours of a request for PA of a drug.

Section 5 Program Integrity

Vermont Medicaid pays only for services that are actually provided and that are medically necessary. In filing a claim for reimbursement, the code should be chosen that most accurately describes the service that was provided, claims should be submitted for only those days that were authorized. It is a felony under Vermont law knowingly to do, attempt, or aid and abet in any of the following when seeking or receiving reimbursement from Vermont Medicaid:

- File a claim for services that were not rendered,
- File a false claim,
- File a claim for unauthorized items or services,
- Bill the member or the member's family for an amount in excess of that allowed by law or regulation,
- Fail to credit the state or its agent for payments received from social security, insurance, or other sources,
- Receive unauthorized payment.

Section 6 Forms

- Request for Reconsideration
- Uniform Medical Prior Authorization Form