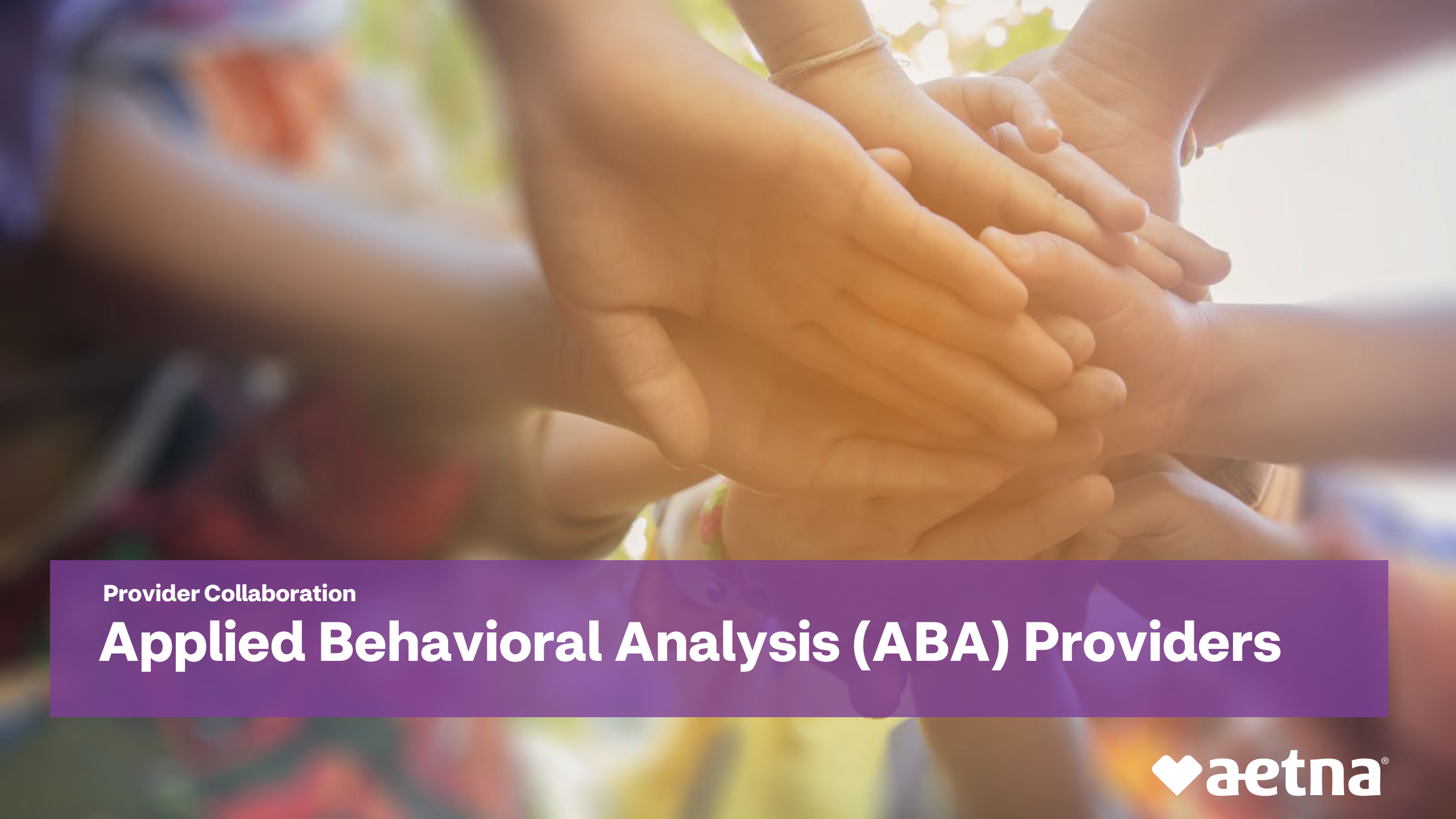

Provider Collaboration

Applied Behavioral Analysis (ABA) Providers

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ABA CPT Codes, Modifiers, and Locations

ABA Codes Green Requires Auth *(97155 auth for all)*	Description	Modifier None *(RPT/UBT)*	Modifier HN *(Bachelors LABA)*	Modifier HO *(Master's LBA)*	Modifier TF *(Other LMHP)*	Modifier - PHE GT can be in addition to other mods.	Location Codes 03, 11, 12, 15, 21, 22, 23, 49, 50, 52, 53, 56, 57, 71, 99
97151	Individual Assessment		✓	✓	✓	✓	✓
97152	Individual Assessment	✓	✓			✓	✓ *(not 03)*
97153	Individual Treatment	✓	✓	✓	✓	✓	✓ (not 03)
97154	Group Treatment	✓	✓	✓	✓	✓	✓ (not 03)
97155	Individual Treatment		✓	✓	✓	✓	✓
97156	Family Training		✓	✓	✓	✓	✓
97157	Group Family Training		✓	✓	✓	✓	✓ (not 03)
97158	Group Treatment		✓	✓	✓	✓	✓ (not 03)
0362T	Assessment: Team Analysis & Treatment, Functional Analysis		✓	✓	✓	✓	✓ (not 03)
0373T	Treatment: Team Analysis & Treatment, Modified Treatment		✓	✓	✓	✓	✓ (not 03)

Authorizations – 97155

Fax:
1-833-757-1583

Initial Authorization
Fax: **1-833-757-1583**

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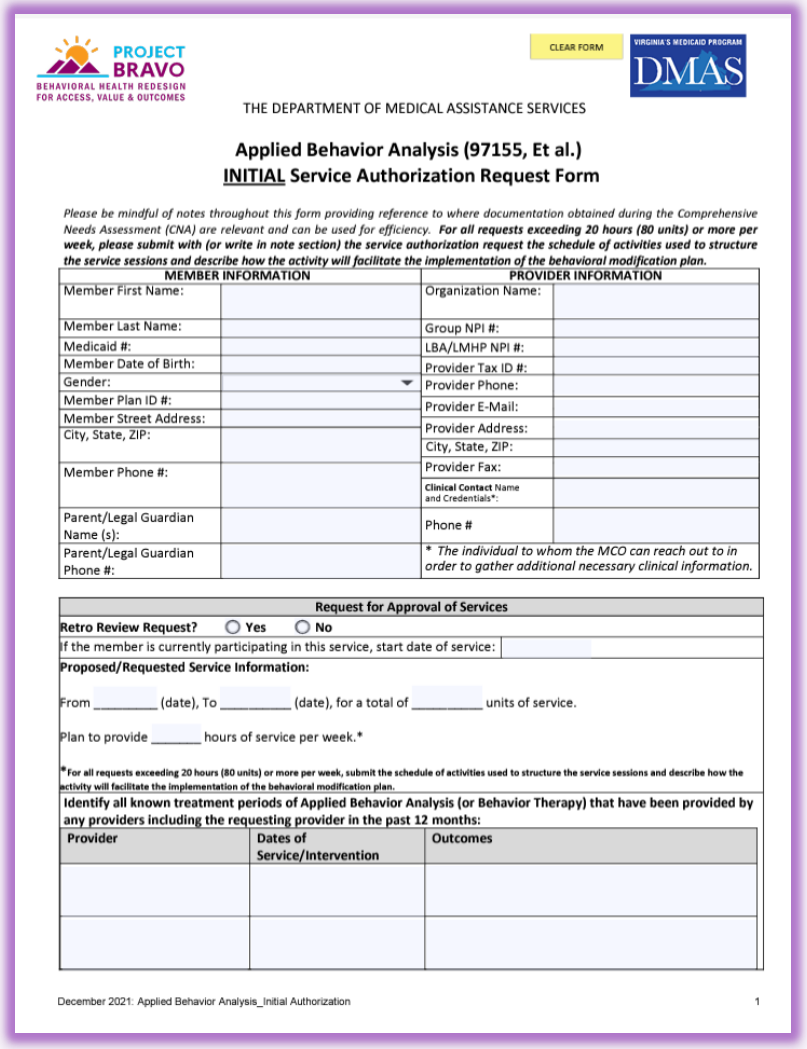
MHS Applied Behavior Health Initial Authorization Helpful Hints



PROJECT BRAVO
BEHAVIORAL HEALTH REDESIGN FOR ACCESS, VALUE & OUTCOMES

CLEAR FORM

VIRGINIA'S MEDICAID PROGRAM DMAS

THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Applied Behavior Analysis (97155, Et al.)
INITIAL Service Authorization Request Form

Please be mindful of notes throughout this form providing reference to where documentation obtained during the Comprehensive Needs Assessment (CNA) are relevant and can be used for efficiency. ***For all requests exceeding 20 hours (80 units) or more per week, please submit with (or write in note section) the service authorization request the schedule of activities used to structure the service sessions and describe how the activity will facilitate the implementation of the behavioral modification plan.***

MEMBER INFORMATION		PROVIDER INFORMATION	
Member First Name:		Organization Name:	
Member Last Name:		Group NPI #:	
Medicaid #:		LBA/LMHP NPI #:	
Member Date of Birth:		Provider Tax ID #:	
Gender:		Provider Phone:	
Member Plan ID #:		Provider E-Mail:	
Member Street Address:		Provider Address:	
City, State, ZIP:		City, State, ZIP:	
Member Phone #:		Provider Fax:	
		Clinical Contact Name and Credentials*:	
Parent/Legal Guardian Name (s):		Phone #	
Parent/Legal Guardian Phone #:		* *The individual to whom the MCO can reach out to in order to gather additional necessary clinical information.*	

Request for Approval of Services
Retro Review Request? ○ Yes ○ No
If the member is currently participating in this service, start date of service:
Proposed/Requested Service Information:
From _____ (date), To _____ (date), for a total of _____ units of service.
Plan to provide _____ hours of service per week.*
*For all requests exceeding 20 hours (80 units) or more per week, submit the schedule of activities used to structure the service sessions and describe how the activity will facilitate the implementation of the behavioral modification plan.
Identify all known treatment periods of Applied Behavior Analysis (or Behavior Therapy) that have been provided by any providers including the requesting provider in the past 12 months:

Provider	Dates of Service/Intervention	Outcomes

December 2021: Applied Behavior Analysis_Initial Authorization 1

- Clinical contact name with credentials and contact information should be the person that the reviewer can reach out to who is familiar with the clinical aspect of the case and include the phone number where they can be reached.
- Detailed information cannot be left on voicemail that is not identified as confidential.
- If you have an administrative contact that you would like us to reach, you may list the name and contact information on the fax cover sheet.
- ***LBA/LMHP NPI****: This is where the authorization lives and should match the* ***claim*** *rendering NPI, no exceptions.*
- *If rendering providers change, then new authorization is required, and the previous authorization will be closed.*

- Include the initial date for services. This should be the date the member entered the service with the provider and is helpful in assessing member's progress in the service.

- List past & present ABA services the member has received. Include details of other medical/behavior health concerns. Utilize the notes section on last page if needed to complete documentation.

- Note the date for the most recent form is located here.

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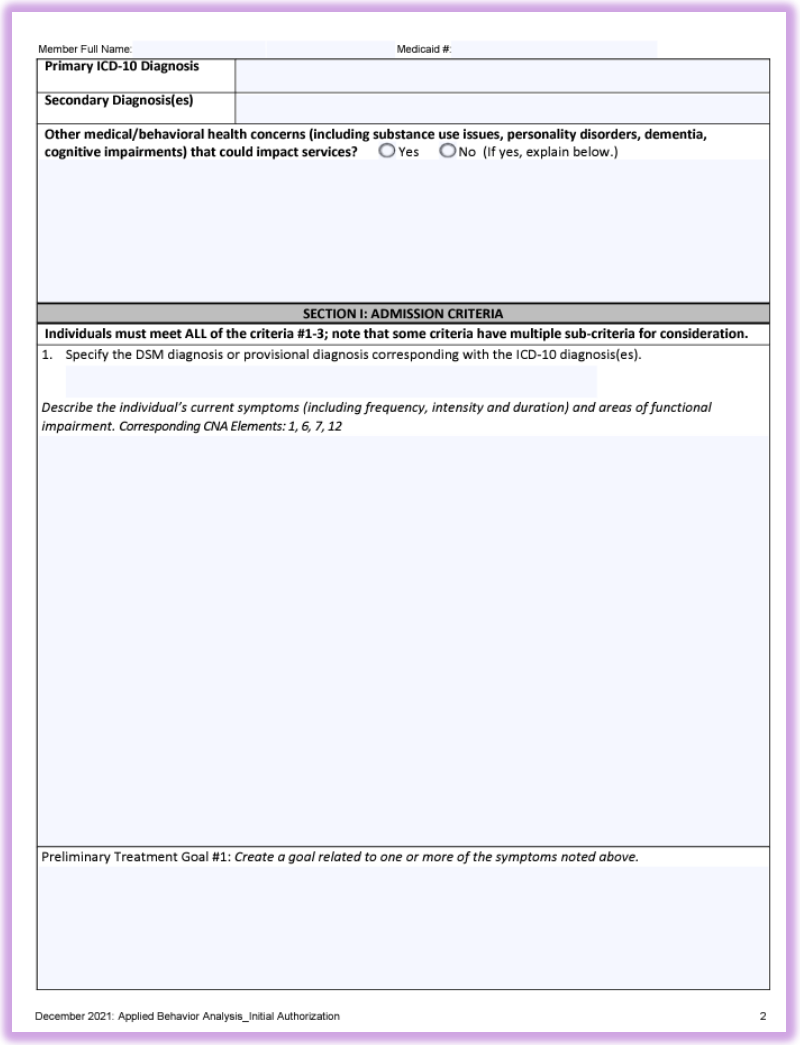
MHS Applied Behavior Health Initial Authorization Helpful Hints



Member Full Name: Medicaid #:

Primary ICD-10 Diagnosis	
Secondary Diagnosis(es)	

Other medical/behavioral health concerns (including substance use issues, personality disorders, dementia, cognitive impairments) that could impact services? ○ Yes ○ No (If yes, explain below.)

SECTION I: ADMISSION CRITERIA

Individuals must meet ALL of the criteria #1-3; note that some criteria have multiple sub-criteria for consideration.

1. Specify the DSM diagnosis or provisional diagnosis corresponding with the ICD-10 diagnosis(es).

Describe the individual's current symptoms (including frequency, intensity and duration) and areas of functional impairment. Corresponding CNA Elements: 1, 6, 7, 12

Preliminary Treatment Goal #1: *Create a goal related to one or more of the symptoms noted above.*

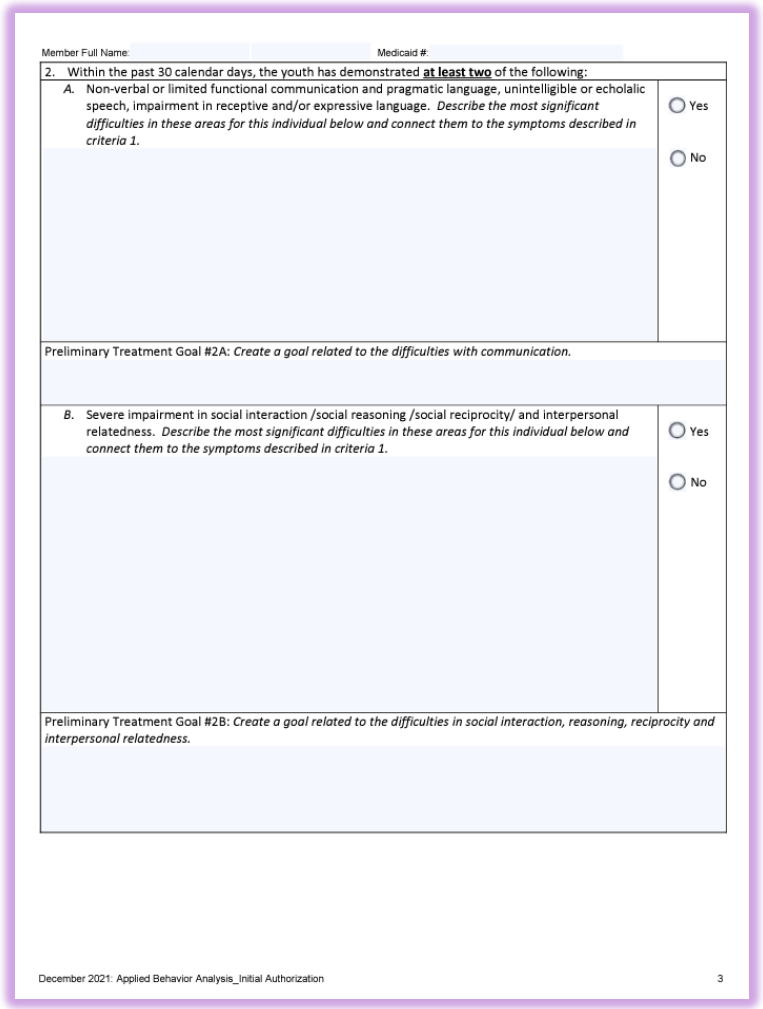
December 2021: Applied Behavior Analysis_Initial Authorization 2

- Include ICD-10 diagnosis. List present and past ABA services the member has received and include details of other medical/behavior health concerns. Utilize the notes section on last page if needed to complete documentation.

- Include details, examples, and specifics.

- Goals should address the symptoms referenced in the assessment for services. Referencing the member's presentation at admission and the improvement that has occurred, or lack thereof, is recommended for measurement.

MHS Applied Behavior Health Initial Authorization Helpful Hints



Member Full Name: Medicaid #:

2. Within the past 30 calendar days, the youth has demonstrated **at least two** of the following:

A. Non-verbal or limited functional communication and pragmatic language, unintelligible or echolalic speech, impairment in receptive and/or expressive language. *Describe the most significant difficulties in these areas for this individual below and connect them to the symptoms described in criteria 1.* ○ Yes ○ No

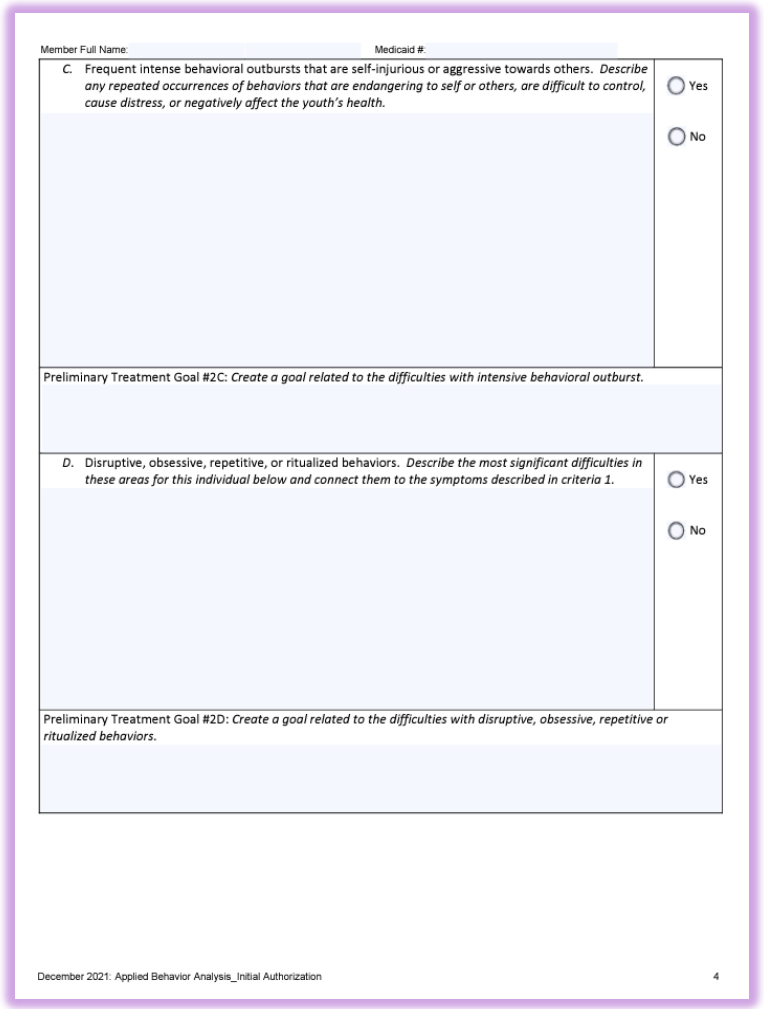
Preliminary Treatment Goal #2A: *Create a goal related to the difficulties with communication.*

B. Severe impairment in social interaction /social reasoning /social reciprocity/ and interpersonal relatedness. *Describe the most significant difficulties in these areas for this individual below and connect them to the symptoms described in criteria 1.* ○ Yes ○ No

Preliminary Treatment Goal #2B: *Create a goal related to the difficulties in social interaction, reasoning, reciprocity and interpersonal relatedness.*

December 2021: Applied Behavior Analysis_Initial Authorization 3

- Complete all sections of each page.



Member Full Name: Medicaid #:

C. Frequent intense behavioral outbursts that are self-injurious or aggressive towards others. *Describe any repeated occurrences of behaviors that are endangering to self or others, are difficult to control, cause distress, or negatively affect the youth's health.* ○ Yes ○ No

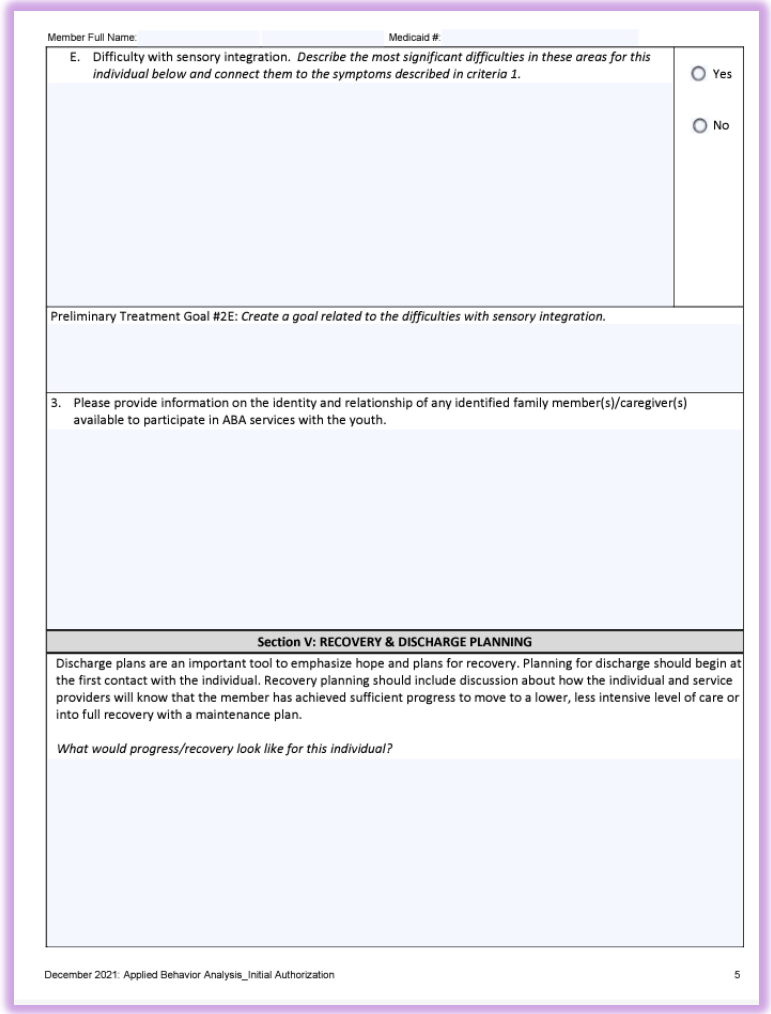
Preliminary Treatment Goal #2C: *Create a goal related to the difficulties with intensive behavioral outburst.*

D. Disruptive, obsessive, repetitive, or ritualized behaviors. *Describe the most significant difficulties in these areas for this individual below and connect them to the symptoms described in criteria 1.* ○ Yes ○ No

Preliminary Treatment Goal #2D: *Create a goal related to the difficulties with disruptive, obsessive, repetitive or ritualized behaviors.*

December 2021: Applied Behavior Analysis_Initial Authorization 4

MHS Applied Behavior Health Initial Authorization Helpful Hints



Member Full Name: Medicaid #:

E. Difficulty with sensory integration. *Describe the most significant difficulties in these areas for this individual below and connect them to the symptoms described in criteria 1.*

○ Yes

○ No

Preliminary Treatment Goal #2E: *Create a goal related to the difficulties with sensory integration.*

3. Please provide information on the identity and relationship of any identified family member(s)/caregiver(s) available to participate in ABA services with the youth.

Section V: RECOVERY & DISCHARGE PLANNING

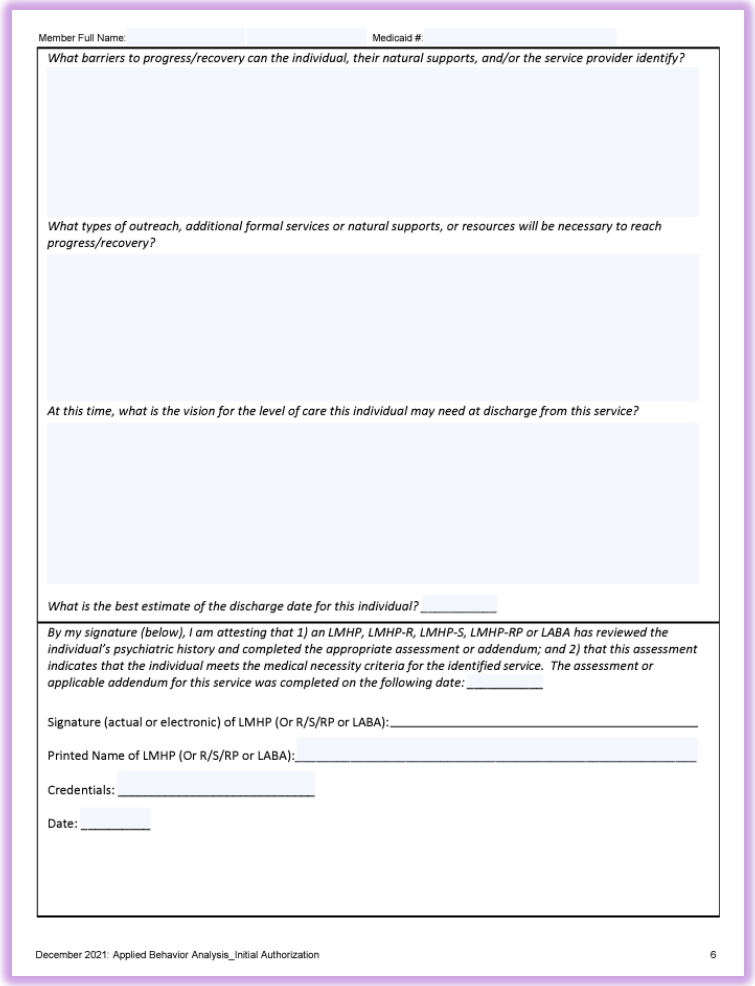
Discharge plans are an important tool to emphasize hope and plans for recovery. Planning for discharge should begin at the first contact with the individual. Recovery planning should include discussion about how the individual and service providers will know that the member has achieved sufficient progress to move to a lower, less intensive level of care or into full recovery with a maintenance plan.

What would progress/recovery look like for this individual?

December 2021: Applied Behavior Analysis_Initial Authorization 5

- Discharge planning should begin at intake.
- Always include an estimated date of discharge.
- Placing “unknown” is acceptable; however, blank submissions are considered incomplete.

MHS Applied Behavior Health Initial Authorization Helpful Hints



Member Full Name: Medicaid #:

What barriers to progress/recovery can the individual, their natural supports, and/or the service provider identify?

What types of outreach, additional formal services or natural supports, or resources will be necessary to reach progress/recovery?

At this time, what is the vision for the level of care this individual may need at discharge from this service?

What is the best estimate of the discharge date for this individual? _____

By my signature (below), I am attesting that 1) an LMHP, LMHP-R, LMHP-S, LMHP-RP or LABA has reviewed the individual's psychiatric history and completed the appropriate assessment or addendum; and 2) that this assessment indicates that the individual meets the medical necessity criteria for the identified service. The assessment or applicable addendum for this service was completed on the following date: _____

Signature (actual or electronic) of LMHP (Or R/S/RP or LABA):_____

Printed Name of LMHP (Or R/S/RP or LABA):_____

Credentials: _____

Date: _____

December 2021: Applied Behavior Analysis_Initial Authorization 6

- Discharge planning continued.
- Always include an estimated date of discharge.
- Placing "unknown" is acceptable; however, blank submissions are considered incomplete.

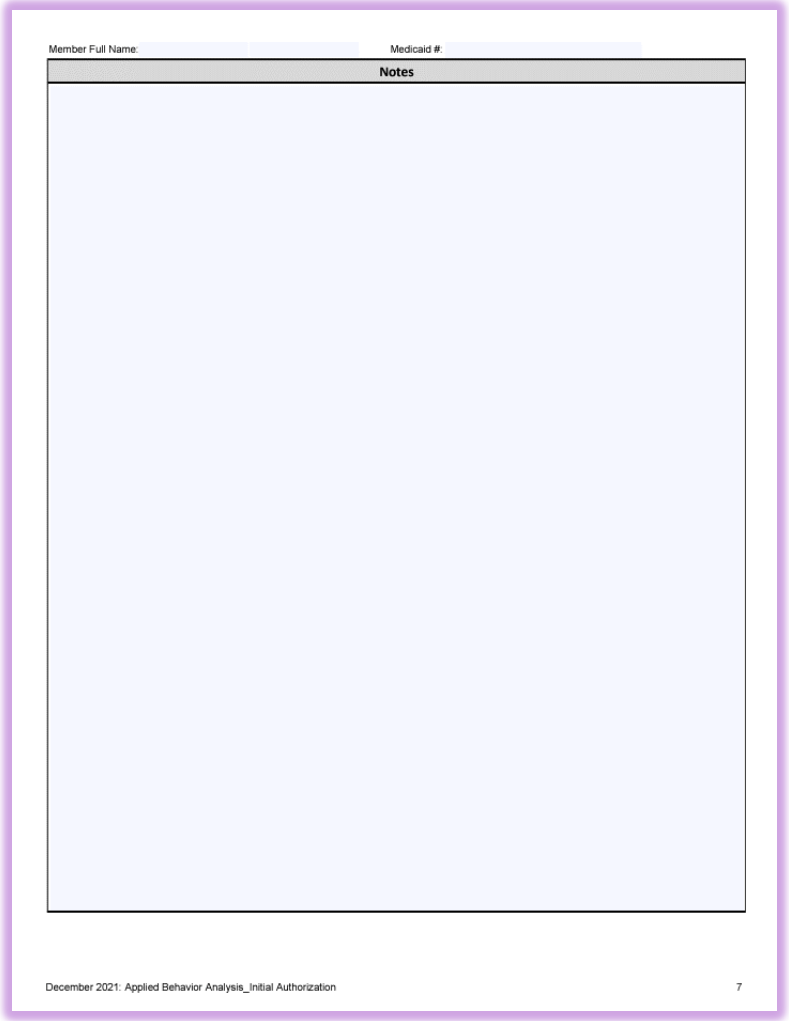
- Please be sure to sign all documents.
- Documents may be signed by hand or electronically signed; however, changing to a signature type font will not suffice.

X *John Smith*

X *John Smith*

X *John Smith*

MHS Applied Behavior Health Initial Authorization Helpful Hints


Member Full Name: Medicaid #:

Notes

December 2021: Applied Behavior Analysis_Initial Authorization 7

- This section can be utilized in a multitude of ways.
- You may reference sections above in the document where you may not have had enough space to clinically document.
- You may also use this space to provide a narrative of symptoms and behaviors, or how the member continues to meet medical necessity for the service.
- Requests should be individualized to match the member's needs.

Continued Stay Authorization

Fax: **1-833-757-1583**

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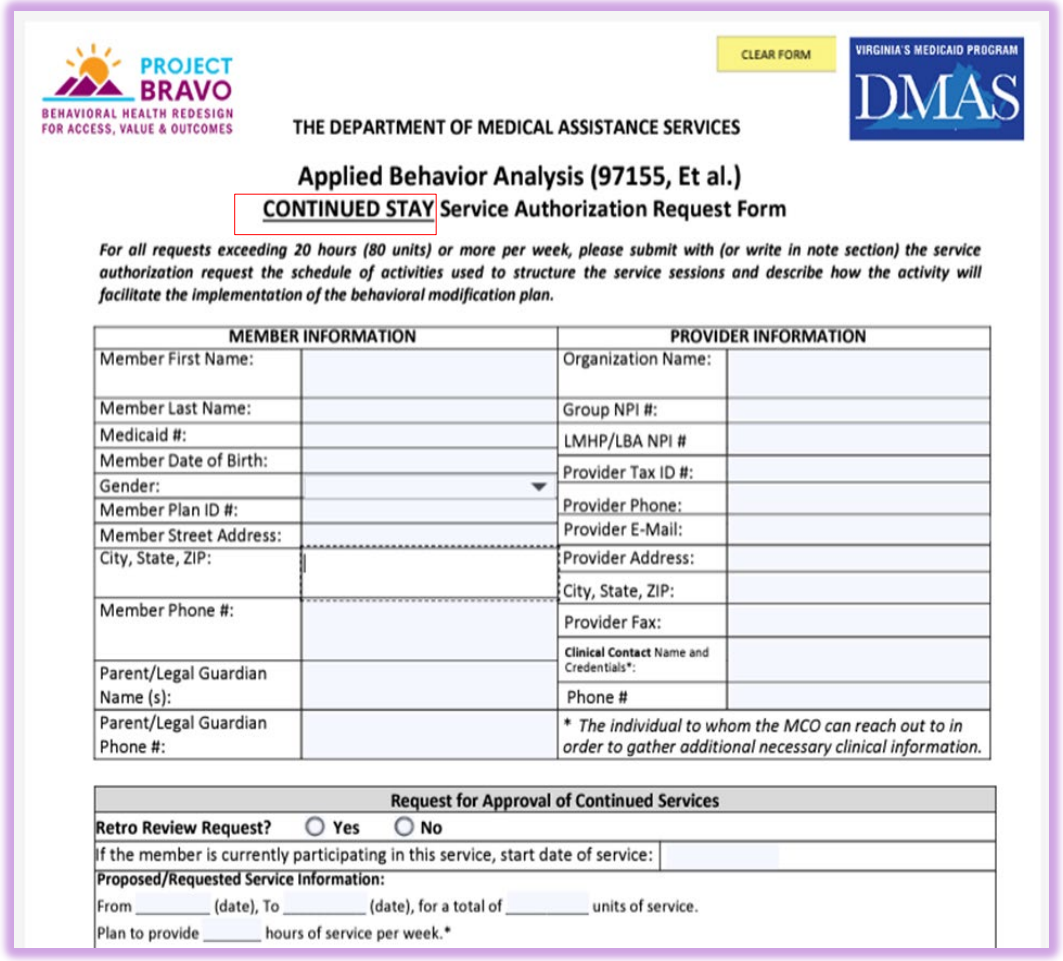
MHS Applied Behavior Health Continued Stay



PROJECT BRAVO
BEHAVIORAL HEALTH REDESIGN FOR ACCESS, VALUE & OUTCOMES

CLEAR FORM

VIRGINIA'S MEDICAID PROGRAM DMAS

THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Applied Behavior Analysis (97155, Et al.)

CONTINUED STAY Service Authorization Request Form

For all requests exceeding 20 hours (80 units) or more per week, please submit with (or write in note section) the service authorization request the schedule of activities used to structure the service sessions and describe how the activity will facilitate the implementation of the behavioral modification plan.

MEMBER INFORMATION		PROVIDER INFORMATION	
Member First Name:		Organization Name:	
Member Last Name:		Group NPI #:	
Medicaid #:		LMHP/LBA NPI #	
Member Date of Birth:		Provider Tax ID #:	
Gender:		Provider Phone:	
Member Plan ID #:		Provider E-Mail:	
Member Street Address:		Provider Address:	
City, State, ZIP:		City, State, ZIP:	
Member Phone #:		Provider Fax:	
Parent/Legal Guardian Name (s):		**Clinical Contact** Name and Credentials*:	
		Phone #	
Parent/Legal Guardian Phone #:		* *The individual to whom the MCO can reach out to in order to gather additional necessary clinical information.*	

Request for Approval of Continued Services
Retro Review Request? ○ **Yes** ○ **No**
If the member is currently participating in this service, start date of service:
Proposed/Requested Service Information:
From _____ (date), To _____ (date), for a total of _____ units of service.
Plan to provide _____ hours of service per week.*

- Fill out each page with appropriate details keeping in mind that each requests should be individualized to match the member's needs and include the appropriate **rendering** provider.
- Review initial authorization tips in previous slides for a successful submission.

Credentialing ABA Providers

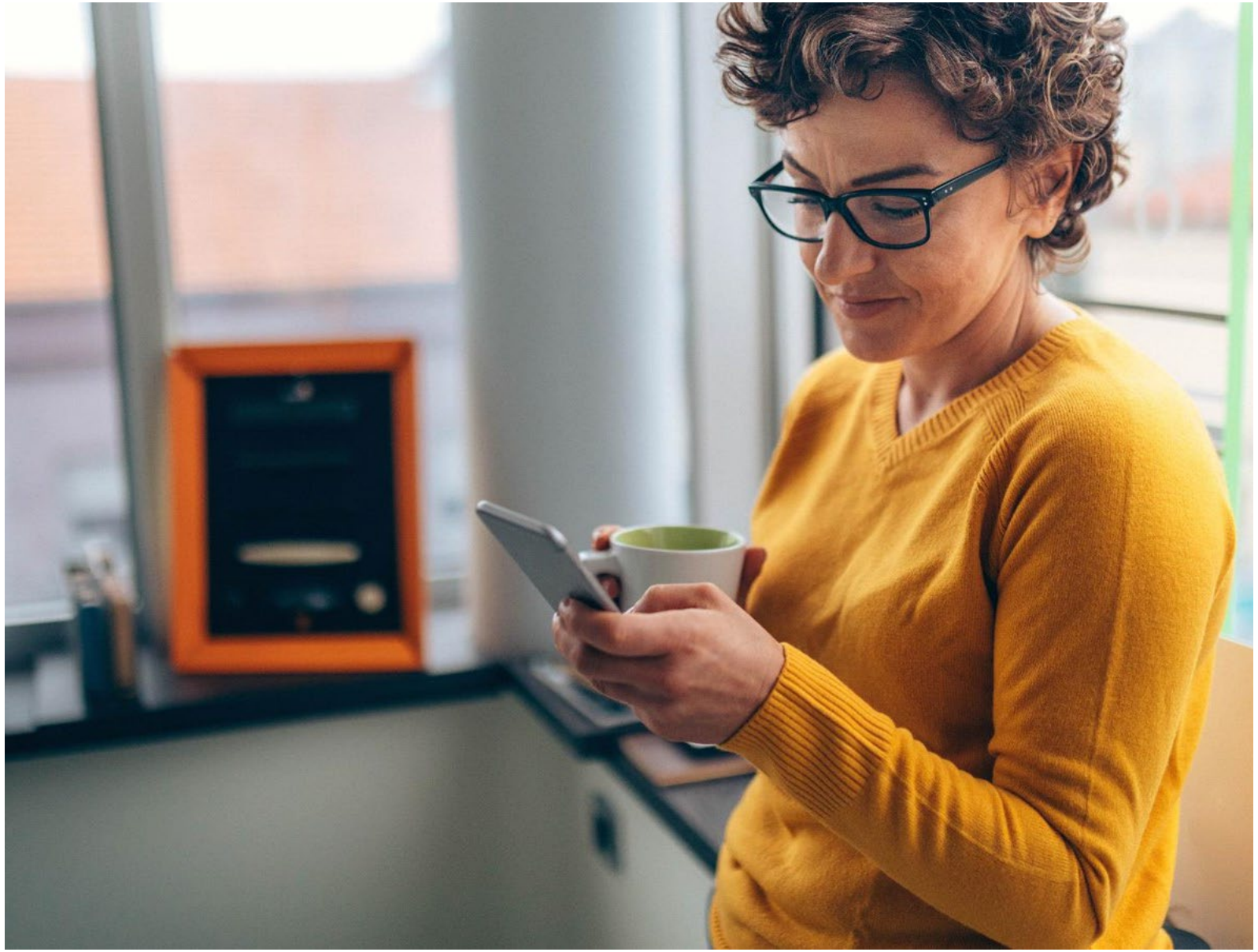
Credentialing to Contracting

- ABA providers must be appropriately licensed and have an NPI.
- ALL providers, including ABA providers, must enroll in the **DMAS Provider Services Solution (PRSS)** and select **Aetna Better Health of Virginia**.
  The portal is a one-stop shop to complete enrollment and maintain provider details, and it satisfies the federal requirements of *the 21st Century Cures Act* for all Medicaid providers.
- Providers adding to existing contracted groups do not need a new contract.
- However, they need enroll in the State **PRSS** portal and be credentialed by our team.
- New groups, with new tax IDs will need to be added via the portal and obtain a contract; their providers will need to be credentialed by our team.
- Alert Providers Relations that you have completed the PRSS process and wish to escalate your request within our credentialing team.
- **Provider Relations email:** AetnaBetterHealth-VAProviderRelations@Aetna.com

Submitting ABA Claims

Tips

- Services provided by unlicensed staff **must** be under the supervision of a licensed ABA provider and the licensed supervising ABA provider **must** have completed credentialing and listed as the rendering provider on the authorization and claim.
- Changing rendering providers requires a new authorization request. Note the previous/old authorization will be **closed**.
- GT modifier is allowed as a result of public health emergency (PHE), and you must use the locations that would have been appropriate had PHE not been in place.
- Use only appropriate state-approved location codes listed in the grid.
- EOB: Not participating attestations
  - Best practice: Attach letter to each submitted claim
- ABA claims guidance and notes on pages 42-46 of Appendix D of DMAS Mental Health Services Appendix D.
- Email AetnaBetterHealth-VAProviderRelations@aetna.com for claims questions and concerns.



Resources

Provider Manuals, Authorization Forms, and License Verification

- State-Maintained Provider Manuals
- Mental Health Services (formerly CMHRS) Provider Manual
- Standardized authorization forms and training for services are posted on the DMAS website. Be sure to use the correct form for the requested service.
- Virginia Department of Behavioral Health and Developmental Services

Useful Information

- After hours crisis number: **1-800-279-1878, option 3**
- Aetna Better Health fax number for authorizations: **1-833-757-1583**
- Provider Relations: **1-800-276-1878**
- Member Services: **1-800-276-1878 (TTY: 711)**

Director, Clinical Health Services, Behavioral Health	Lauren Bayes, LPC	804-389-1991	BayesL@cvshealth.com
Manager, Clinical Health Services, Behavioral Health	Genhi Whitmer, LPC	434-981-9113	WhitmerG@aetna.com
Senior Clinical Strategist, ARTS Care Coordinator	Stephen Ratliff, LPC	540-488-4725	RatliffS@aetna.com
Central, BH Clinical Liaison	Megan Demaline, LPC	959-299-7918	DemalineM@aetna.com
Central, BH Clinical Liaison	Sha'Vonne Harrison, LPC	804-778-0907	HarrisonS1@aetna.com
Central, BH Clinical Liaison	Acey Tucker, LPC	804-619-2270	TuckerA@aetna.com
Central, BH Clinical Liaison	Nicole Simmons-Jackson, LCSW	804-316-1385	SimmonsC2@aetna.com
Charlottesville, BH Clinical Liaison	Brenda Hardley, LCSW	717-304-4649	HardleyB@aetna.com
Charlottesville, BH Clinical Liaison	Jessica Ketola, LPC	434-394-9297	KetolaJ@aetna.com
Northern Virginia, BH Clinical Liaison	Mary Philpott, LPC	202-494-8879	PhilpottM@aetna.com
Northern Virginia, BH Clinical Liaison	Jessica Kim, LPC	571-262-1761	KimA1@aetna.com
Northern Virginia, BH Clinical Liaison	Maurice Jones, LPC	757-323-0352	JonesM10@aetna.com
Roanoke, BH Clinical Liaison	Kelly Clinevell, LPC	540-759-4141	ClinevellK@aetna.com
Roanoke, BH Clinical Liaison	Jennifer Greer, LCSW	276-781-4841	GreerJ4@aetna.com
Roanoke, BH Clinical Liaison	Elizabeth Crouse, LCSW	276-385-0249	CrouseE@aetna.com
Southwest, BH Clinical Liaison	Saborah Holmes, LPC, CSAC	276-594-1308	HolmesS4@aetna.com
Southwest, BH Clinical Liaison	Dave Hibbitts, LPC	276-696-9927	HibbittsP@aetna.com
Tidewater, BH Clinical Liaison	Pamela Williams, RN	757-381-3532	WilliamsP@aetna.com
Tidewater, BH Clinical Liaison	Alisha Jones, BSN, RN	757-342-5691	JonesA29@aetna.com

Behavioral Health Clinical Liaison Team

Contact Information

Address:	Aetna Better Health of Virginia 9881 Mayland Drive Richmond, VA 23233
Paper claims submission:	Aetna Better Health of Virginia Attn: Claims Department PO Box 982974 El Paso, TX 79998-2974
Public website:	**AetnaBetterHealth.com/Virginia**
Portal website:	**AetnaBetterHealth-Virginia-Aetna.com**
Member Services and Provider Relations:	**1-800-279-1878**
Provider and authorization fax:	**1-833-757-1583**

Appeals Process

- Denials based on medical necessity criteria:
  - You have 7 calendar days to request a peer-to-peer reconsideration. to request a peer-to-peer, call Member Services at **1-833-459-1998**.
  - If you are not satisfied with the peer-to-peer result, you can submit a formal appeal with Aetna Better Health. If you are not satisfied with the appeal result, you may then submit a formal appeal to DMAS.
- Denials based on administrative reasons (i.e., OON provider, missing pages or signatures from the CMHRS/BRAVO/ARTS form, untimely submission)
  - Send appeal request using the formal provider appeal process.
  - Appeals should state **FORMAL PROVIDER APPEAL** on the document(s) and should be mailed to:

    Aetna Better Health of Virginia
    Attn: Appeals Coordinator
    9881 Mayland Drive, Richmond, VA 23233-1458
    Fax: **866-669-2459**

- Reviewers may not always ask for additional clinical information. If a service is denied, you will be contacted by the reviewer, faxed a denial authorization, faxed a denial letter, and a denial letter will be mailed to you.

Quick Reference Guide for Providers

Claims and Resubmissions

- Member's name
- Member's date of birth
- Member's identification number
- Service/admission date
- Location of treatment
- Service or procedure

Timely Filing

- New Claim/Corrected Claim - 365 days from date of service or discharge
- Coordination of benefit claim (COB) – 365 days from the date of the primary (EOB)

Transition of Care Period for Medical and Pharmacy

- 180 days from member's effective date for Medallion 4.0 and 30 days for CCC Plus

Electronic Claims Submission – Change Healthcare (Emdeon)

- 1-877-363-3666
- www.changehealthcare.com

EDI payor ID (837 Claims) – 128VA

- To get real time responses to eligibility/claim/auth inquiries use ID **ABHVA** (270/271; 276/277; 278)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