CareSource

REIMBURSEMENT POLICY STATEMENT
Nevada Medicaid

Policy Name & Number	Date Effective
Applied Behavior Analysis for Autism Spectrum Disorder-NV MCD-PY-1695	01/01/2026
Policy Type	
REIMBURSEMENT	

Reimbursement Policies are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design, and other factors are considered in developing Reimbursement Policies.

In addition to this policy, reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreements, and applicable referral, authorization, notification, and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

This policy does not ensure an authorization or reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Reimbursement Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination. We may use reasonable discretion in interpreting and applying this policy to services provided in a particular case and we may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject
Applied Behavior Analysis for Autism Spectrum Disorder

B. Background
Provider reimbursement issues for Applied Behavior Analysis (ABA) services for Autism Spectrum Disorder (ASD) can arise from various factors, impacting families, providers, and the accessibility of care. Key issues relating to payment problems include coverage issues, billing and coding challenges, access to services, and legislative and policy issues. Billing and coding issues are common due to a variety of factors, including the complexity of coding, incorrect coding, insufficient documentation, authorization issues, and billing for supervision and telehealth services.

CareSource strives to provide clear practices regarding reimbursement for services and follows federal and state guidance, including Nevada statutes. Medical criteria for the provision of ABA services is located in CareSource's Applied Behavior Analysis for Autism Spectrum Disorders medical policy at www.caresource.com under the Provider tab. Any information provided by the State of Nevada or the *Medicaid Services Manual* (*MSM*) supersedes information in this policy.

C. Definitions
- **Medically Unlikely Edit (MUE)** – Maximum units of service for 1 Current Procedural Terminology (CPT) code a provider can report for 1 member on 1 date of service.

D. Policy
I. General Provisions
A. Reimbursement Rules
1. Members and providers must adhere to the Nevada *MSM* and other Nevada direction, including guidance for provider type 85, which outlines the following limits for authorization applying to the total combined number of units of codes 97153, 97155 and 0373T:
   a. Focused Delivery Model: 15-25 hours per week for all ABA services.
   b. Comprehensive Delivery Model: 25-40 hours per week for all ABA services.
2. Section D.II. *Covered Services* provides instruction on medical necessity reviews per covered service. Some services require review prior to service provision. Delivery Model limits may be exceeded with prior authorization and documentation of medical necessity. Requests above the policy limits will be reviewed on a case-by-case basis.
3. Covered services use fee schedule reimbursement methodology in which reimbursement is made at the lower of the billed charge for the service or the maximum allowable reimbursement for the service. The maximum allowable reimbursement for a service is the same for all ABA providers.
4. Time spent preparing a member for services, cleaning or prepping an area before or after services, and/or rest or other break times between service activities is not

billable, nor is time spent on documentation alone unless otherwise specifically permitted by code definition.

5. The maximum number of units that can be used for supervision is 20% of the total number of hours of direct therapy services provided, unless clinical documentation is provided that supports a need for additional units.
6. Providers are limited to 12 hours of ABA services per day.
7. Members are limited to 40 hours of ABA services per week.
8. Telemedicine services are reimbursed in the same manner and subject to the same limits as in-person, face-to-face service delivery.
9. ABA services cannot be reimbursed on the same day as Basic Skills Training (BST) and Psychosocial Rehabilitation (PSR) as defined in *MSM* Chapter 400. Refer to Medicaid billing guides and the *Current Procedural Terminology (CPT)* book for guidance.

B. Documentation Requirements

States enact documentation requirements for member records maintained for third party billing. All written, electronic, and other records will be stored and disposed of in such a manner as to ensure confidentiality, and all must be legible.

1. Supervision documentation

   The State of Nevada and the BACB enacts supervision requirements and documentation guidelines for providers. If there are discrepancies with supervision documentation, the associated claims are subject to recoupment. CareSource reserves the right to request documentation, including telehealth documentation, and expects providers to follow provisions adopted by the BACB, including all ethical guidelines provided by the BACB.

   a. A BCBA delivering direct one-on-one ABA therapy treatment services to a member (ie, not supervising a BCaBA or RBT perform an ABA therapy treatment session) is not considered an adaptive behavior treatment with protocol modification service and must be billed as an ABA therapy treatment service.
   b. Adjusting and updating an existing treatment plan as required is considered an adaptive behavior treatment with protocol modification service.
   c. A supervising BCBA must review and approve the data collection and progress notes completed by a BCaBA or RBT under supervision prior to submitting a claim for any ABA therapy treatment services delivered.

2. Progress notes

   Progress notes are written documentation of treatment services or services coordination provided to the member pursuant to the treatment plan, IEP, POC, or 504 Accommodation Plan, which describes progress, or lack of, towards goals and objectives. Progress notes must be available upon request for review and investigation of claims.

   a. All progress notes documented with the intent of submitting a billable Medicaid ABA service claim must be documented in a manner sufficient to support the claim and billing of the services provided and must further document the amount, scope, frequency, and duration of the services(s) provided as well as the identity of the provider of the service(s).

b. A progress note is required for each day services were delivered and include the information found in section 3704.4 G of the *MSM* in addition to identification of all present during the session(s).

II. Covered Services

Covered services are only reimbursable when delivered in accordance with the member's treatment plan or plan of care and must be prescribed on the treatment plan. Services may be delivered in individual or group (2 to 8 individuals) sessions and in the natural setting (ie, home, school, community-based settings, including clinics). Descriptions about components and characteristics of Focused and Comprehensive Delivery Models can be located in the *MSM*. Services covered within these models include the following:

A. Behavioral Screening
Chapter 600 of the *Medicaid Services Manual* (*MSM*) discusses coverage of developmental screens and provides a list of nationally accepted screens. Behavior screens do not require prior authorization.

B. Comprehensive Evaluations
These evaluation further review and diagnose the child's behavior and development. Coverage of this service is found in *MSM* Chapter 600.

C. Behavior Assessment
Behavior initial assessment and re-assessments do not require prior authorization. Assessments are limited to 1 every 180 days or unless prior authorized. A comprehensive assessment is an individualized exam establishing the presence or absence of developmental delays and/or disabilities and determining readiness for change. It identifies strengths or problem areas affecting treatment. The information collected determines appropriate interventions and treatment planning. The unit of service calculation should only include face-to-face time spent by the BCBA with the member and/or parent/guardian conducting a comprehensive evaluation and any non-face-to-face time spent by the BCBA preparing the accompanying comprehensive evaluation report and developing the member's initial treatment plan. The process includes an extensive recipient history, which should include, at a minimum
1. current medical conditions and past medical history
2. labs and diagnostics with medication and substance use history
3. legal history
4. family and social history
5. educational history
6. risk assessment

D. Adaptive Behavior Treatment Intervention
This services requires a review of medical necessity prior to service provision and includes the systematic use of behavior techniques and intervention procedures, including intensive direction and instruction by the provider and family training and support.

E. Adaptive Behavior Family Treatment
This service requires review of medical necessity prior to service provision and includes extensive, ongoing training in behavior techniques incorporated into daily routines of the child and consistent with the intervention approach, including regular

consultation with the qualified professional. Services are reimbursed on a per unit basis and include time spent collaborating face-to-face with the parent/guardian or representative. There are 2 components:

1. Family Treatment with the Child Present – Training that includes the parent/guardian or authorized representative in behavior techniques during the behavior intervention with the child.
2. Family Treatment without the Child Present – Training in behavior techniques provided to the parent/guardian or authorized representative without the child present or for the review of prior adaptive behavior treatment sessions to break down the exhibited behavior and training techniques.

III. Codes of Conduct

Codes of conduct function to protect members by establishing, disseminating, and managing professional standards and are mandated by states. CareSource supports professional standards established by licensing and credentialing bodies and therefore encourages professional compliance to any and all standards across disciplines for the protection of members and families. The BACB ethics code should be followed, including any related to the provision of supervision.

IV. Special Provisions Related to RBTs

A. Current Standards for RBTs

1. RBT services must be supervised by a qualified RBT supervisor (ie, BCBA, BCBA-D, licensed psychologist who tested in ABA and certified by the American Board of Professional Psychology in Behavioral and Cognitive Psychology) and obtain ongoing supervision for a minimum of 5% of the hours spent providing ABA services per month. The BACB publishes information regarding the structure of supervision and parameters for group/individual supervision in the RBT Handbook.
2. A BACB-certified RBT may provide ABA under the supervision of an independent practitioner if affiliated with the organization under which the provider is employed or contracted. If the independent practitioner leaves the affiliated organization and no longer provides supervision, the RBT may not continue to provide services under that independent practitioner. If the RBT leaves the affiliated organization and no longer receives mandated supervision, the RBT may not continue to provide services to the member.
3. Appropriate modifiers indicating qualifications of staff delivering services must be used, if applicable.
4. CareSource will allow providers 60 days from the date of hire for RBTs to complete the RBT credentialing process with the BACB.

B. Upcoming RBT Changes from the Behavior Analyst Certification Board

1. **Effective January 1, 2026**: RBT supervisors must hold BCBA or BCaBA certification. Noncertified supervisors will not be allowed to provide BACB-required supervision to RBTs. During this transition, RBT Requirements Coordinators who currently attest to the qualifications of noncertified supervisors should make preparations to ensure continuity of care for clients.

2. **Effective January 1, 2026:** The BACB adopted new rules regarding eligibility for and maintenance of certification for RBTs located in the BACB Newsletter: December 2023 at www.bacb.com.

V. Exclusions

Reimbursement for the following services or activities is not permitted:

A. reimbursement for the following services or activities is not permitted:
   1. any services not documented in the treatment plan or not meeting medical necessity requirements
   2. behavioral methods or modes considered experimental
   3. education-related services or activities described under Individuals with Disabilities Education Improvement Act of 2004, 20 U.S.C. §1400 (IDEA), amended through Public Law 114-95, the Every Student Succeeds Act
   4. vocational services in nature or those available through programs funded under Section 110 of the Rehabilitation Act of 1973
   5. components of adult day care programs

B. treatment solely for the benefit of the family, caregiver, or therapist, reimbursement of the parent/guardian for participation in treatment planning or services rendered by the parent/guardian
C. treatment focused on recreational, educational or vocational outcomes
D. treatment worsening symptoms or prompting member regression
E. treatment for symptoms and behaviors not part of core symptoms of ASD
F. goals focused on academic targets
G. treatment unexpected to cause measurable, functional improvement or improvement is not documented
H. duplicative therapy services addressing the same behavioral goals using the same techniques as the treatment plan, including services under an IEP, or care coordination and/or treatment planning billed independently of direct service
I. care primarily custodial in nature and not requiring trained/professional ABA staff
J. shadowing, para-professional, or companion services in any setting
K. personal training, life coaching, respite services, child care, or phone consultation
L. services more costly than an alternative service(s), which are likely to produce equivalent diagnostic or therapeutic results for the member
M. any program or service performed in nonconventional settings, even if performed by a licensed provider (eg, spas/resorts, vocational or recreational settings, Outward Bound, wilderness, camp or ranch programs), including equine therapy and hippotherapy

E. Conditions of Coverage

I. When a member has other insurance, Medicaid is always the payer of last resort. CareSource will not pay more than the Medicaid rate totals for service. Primary payer must provide evidence of determinations for consideration of Medicaid coverage for services.

II. Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis, subsequent medical review audits, recovery of overpayments identified, and provider prepayment review.

III. Providers cannot submit multiple dates of service on a single claim line. Each claim line must be specific to a single date of service and the units provided on that single date of service.

IV. CareSource complies with the Centers for Medicare and Medicaid Services (CMS) medicaid medically unlikely edit (MUE) table. If CMS updates the MUE list, the update will take precedence over this policy.

V. Treatment codes are based on daily total units of service in 15-minute increments. A unit of time is attained when the mid-point is passed.

VI. The following code set has been provided for informational purposes only. These codes may be used to identify a service as part of ABA treatment. It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment. Please refer to the applicable fee schedules for appropriate codes.

CPT Codes	Code Description	Session Limit
97151	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan	1 session of 16 units per 180 days
97152	Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes	1 session of 4 units per 180 days
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes	PA required
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes	PA required
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes	20% of total treatment hours; PA required

97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes	4 units (1 hour) per calendar week
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes	1 session of 4 units per calendar month
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes	PA required
0362T	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of 2 or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.	1 session of 4 units per 180 days
0373T	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of 2 or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.	PA required

F. Related Policies/Rules

Applied Behavior Analysis for Autism Spectrum Disorder medical policy

G. Review/Revision History

	DATE	ACTION
Date Issued	08/13/2025	New policy. Approved at Committee.
Date Revised		
Date Effective	01/01/2026	
Date Archived		

H. References

1. Applied Behavior Analysis, NEV. REV. STAT. §§ Chapter 641D.
2. *BACB Newsletter*. Behavior Analyst Certification Board; September 2023. Accessed August 2, 2025. www.bacb.com
3. *BACB Newsletter*: Introducing the 2026 RBT Examination and Certification Requirements. Behavior Analyst Certification Board; December 2023. Accessed August 2, 2025. www.bacb.com
4. *Board Certified Behavior Analyst Handbook*. Behavior Analyst Certification Board. Updated December 2023. Accessed August 2, 2025. www.bacb.com
5. *Board Certified Assistant Behavior Analyst Handbook*. Behavior Analyst Certification Board. Updated December 2023. Accessed August 2, 2025. www.bacb.com
6. Contents of a Request for a Waiver, 42 C.F.R. § 441.301 (2024).

The REIMBURSEMENT Policy Statement detailed above has received due consideration as defined in the REIMBURSEMENT Policy Statement Policy and is approved.

7. Definitions, 42 U.S.C. 1396d (2019).
8. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under Age 21, 42 C.F.R. Subpart B, 441.50-441.62 (1984).
9. Ethics Code for Behavior Analysts. Behavior Analyst Certification Board; 2020. Updated January 1, 2022. Accessed August 2, 2025. www.bacb.com
10. *NCCI MUE Edits-Practitioner Services*. Centers for Medicare and Medicaid Services. Accessed August 2, 2025. www.cms.gov
11. *Provider Type 85 Billing Guide*. Nevada Division of Health Care Financing and Policy. Updated March 4, 2025. Accessed August 2, 2025. www.medicaid.nv.gov
12. *Registered Behavior Technician Handbook*. Behavior Analyst Certification Board. Updated December 2023. Accessed August 2, 2025. www.bacb.com
13. State Plans for Medical Assistance, 42 U.S.C. 1396(a) (2020).