Public Comments on Proposed Rules to be Adopted for the Medicaid Coverage of Applied Behavior Analysis (ABA)
RULE 5160-34-01, RULE 5160-34-02, RULE 5160-34-03
From: The Ohio Autism Insurance Coalition
December 2, 2024

Director Corcoran,

Thank you for the opportunity to comment publicly on ODM: ERF 188422: Applied Behavior Analysis (ABA) and also called Adaptive Behavior Services) rules. I am writing today on behalf of the Ohio Autism Insurance Coalition, a group of 48 ABA providers and community and family stakeholders working together to improve the landscape of private and public reimbursable insurance services for Autism Spectrum Disorder (ASD), including ABA in Ohio.

We appreciate the Ohio Department of Medicaid (Department) and Milliman's efforts to continue developing the ABA coverage and building rates from the bottom up. Indeed, this long journey has landed us on a draft policy and proposed rates that we believe will finalize and stabilize services and open access to care for children, teens, and young adults with ASD and other behavioral health conditions and their families. Thank you.

Please see below our areas of concern for each of the three proposed rules.

Rule 5160-34-01 "Eligible provider and qualifications"

We appreciate the Department's recognition of the three-tiered ABA service delivery model[1] and including Certified Ohio Behavior Analyst (COBA-BCBA) in defining allowable independent providers and assistant behavior analyst (BCaBA) within the allowable dependent providers.

Concern (A) (1) (a): Adaptive Behavior Service Providers, Practitioners

Recommendation: We request the Department add the COBA requirement for all BACB-certified independent practitioners listed under (A)(1)(a).

Recommendation: We request the Department add a third ABS independent practitioner type per the COBA[2] rules 4783.02 (1) and (2) of OAC for the following two practitioner types: (1) An individual licensed under Chapter 4732. of the Revised Code to practice psychology, if the practice of applied behavior analysis engaged in by the licensed psychologist is within the licensed psychologist's education, training, and experience; (2) An individual licensed under Chapter 4757. of the Revised Code to practice counseling, social work, or marriage and family therapy, if the practice of applied behavior analysis engaged in by the licensed professional counselor, licensed professional clinical counselor, licensed social worker, or licensed marriage and family therapist is within the licensee's education, training, and experience.

In our comments, we will refer to the practitioners listed in this recommendation as LIBHP or licensed independent behavior health practitioners.

Recommendation: We request the Department uniformly utilize the term "ABS independent practitioners" or " ABS dependent providers" throughout the ABS rules. Other terms used in the rule are independent service practitioners, independent ABA practitioners, dependent adaptive behavior service providers, and dependent service providers.

[1] Council for Autism Service Providers (CASP) (2024). *Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Manager, (*GASC) *https://www.casproviders.org/standards-and-guidelines*
[2] Ohio administrative code, Certified Ohio Behavior Analysts (COBA) https://codes.ohio.gov/ohio-revised-code/section-4783.02

Concern (A) (2) (b): Requirement of RBTs to Deliver Direct Treatment.

The rule states that the direct care staff, called Technicians, who deliver ABA treatment (97153) must become certified Registered Behavior Technicians (RBT) before delivering billable services. This requirement is costly to providers and pushes Medicaid beneficiaries to wait longer to start treatment. It takes 90 to 120 days for a Technician to become certified as an RBT.

With Ohio's current workforce shortages and the large number of Medicaid-eligible children with ASD waiting on treatment services, we request the Department consider allowing Technicians to become billable sooner. Technicians should become billable once they have completed the 40-hour training protocol, training within therapy sessions, and pass a competency assessment performed by the supervising BCBA/COBA/LIBHPs. Once deemed competent in delivering services, the technician's services should become billable. The Technician can then schedule the RBT certification test.

Along with 40% of states, the state up north does not require the RBT certification, and South Carolina allows a 60-day grace period.

Family Impact: This would reduce the wait time for families to start treatment services by 30 to 60 days. We are unaware that other behavioral direct care staff are waiting up to 90 to 120 days to become billable.

Recommendation: We request the Department allow for a four-month timeline for a technician to achieve RBT certification. Once the technician has completed training and is deemed competent by the supervising BCBA/COBA/LIBHP, they can begin delivering billable ABA treatment.

Concern (C) (2) (c): Lack of clarity on Community Behavioral Health Centers (CBHC) ability to deliver ABA.

Family Impact: Today, some individuals with autism receive ABA treatment along with other mental health services from CBHCs. These providers are critical to families with Medicaid and children with autism, especially in very rural areas. We want to ensure that an individual with autism who also needs crucial non-ABA related CPST services can access them while receiving ABA either under the 9000 CPT codes or CBHC codes.

Recommendation: To increase transparency, we request that the Department consider adding Community Behavioral Health Centers (CBHC) to the list of organizational providers within the rules and clarify they can provide ABA through either 9000 ABS codes and/or CBHC services CPST or TBS.

Rule 5160-34-02 "Covered adaptive behavior services"

We appreciate the Department recognizing all the adaptive behavior service CPT codes and providing consistency in the service names and descriptions per the AMA's ABS CPT[3] codes. This rule needs to clarify two items: whether the Department plans to limit ABA coverage to the age of 21, as stated in 5160-34-03 (C)(1)(a), and a definition of for caregivers that would also align with COBA regulations, OAC 4783.02 OAC, requiring training and collaboration with other service professionals. ASD does not end at age 21, and adults will need periodic access to Focused ABA Interventions (with technicians) or a single Independent Provider service (without technicians) to maintain stability or achieve skills needed for everyday functioning, especially when other services have been unable to achieve the skill or behavior reduction. "Focused ABA refers to treatment, provided directly to the patient, to improve or maintain behaviors in a limited number of domains or skill areas. Access to focused intervention should not be restricted by age, cognitive level, diagnosis, or co-occurring conditions."[4]

[3] American Medical Association, 2024, *CPT Codes Manual*, https://www.ama-assn.org/practice-management/cpt

[4] Council for Autism Service Providers (CASP) (2024). *Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Manager, (*Generally accepted standards of care), page 30, See footnote 1.

According to the Mental Health Parity and Addiction Equity Act (MHPAEA[5]), there is no age limit for accessing ABA treatment for ASD, and adults with ASD are entitled to request and be offered a medical necessity determination for ABA treatment under the protections of the law.

Concern (A) Scope: We request the Department state this coverage is specifically for the ESPDT[6] delivery of ABA and add language on how adults with ASD over the age of 21 will be offered an individualized medical necessity determination through their enrolled managed care plan (MCO) for Focused ABA Interventions or CPST/RBS under CBHC services. MCOs are required to follow MHPAEA law.

Recommendation (C)(d): We request the Department expand the list of diagnoses that can access ABA to include global developmental delay, intellectual disability and ADHD and not for consideration within (viii).

Concern (B)(6) and (C)(2)(b)(vi): Definitions: We request the Department add a definition of caregiver. We consider caregivers to include grandparents and other non-parent/guardian family members, direct service professionals found in home health care or the developmental disability waivers, and other service professionals working with the child, such as OhioRise or educational staff that could benefit from training found in Adaptive Treatment Guidance (97156).

Rule 5160-34-03 "Coverage, limitations, and reimbursement"

We are grateful for the many additions and subtractions this rule makes from previous requirements mentioned in stakeholder meetings, especially in the current seven different MCO medical policies. We applaud the Department's decision not to limit ABA to ASD but to allow other conditions that may benefit if medically necessary. ADHD is one condition that falls into this category.

Also, three key improvements to support families are allowing self-care activities (B)(2), no longer requiring authorizations for 97151 assessment services when requesting up to 10 hours, and allowing referrals to ABA from licensed practitioners within their scope of practice (C)(1)(b), which will help children access services sooner by expanding the very limited practitioners currently in the MCOs medical policies. We were also pleased not to see a recurring requirement every three years for a comprehensive re-diagnostic evaluation, which is burdensome for families since Ohio does not have the diagnostic practitioner framework to meet such a requirement. We are also pleased the Department will no longer require accreditation for ABA providers, which is a significant step forward at this time.

Concern (B)(1) & (C)(1)(c): Burdensome initial diagnostic process required to start treatment services even when clear, identifiable autism symptoms are present.

We need consistent language between this rule and the September 2024 guidance memo from the Center for Medicaid & Medicare Services (CMS) regarding *Best Practices for Adhering to Early and periodic* screening*, Diagnostic, and Treatment (EPSDT) Requirements*.[7] The memo states starting treatment services, including ABA, is based on medical necessity and by referral from a licensed practitioner within the practitioner's scope of practice, whether the child or youth has a formal, comprehensive diagnostic evaluation available for review or not.

[5] CMS,(2024), Federal Mental Health Parity, https://www.cms.gov/marketplace/private-health-insurance/mental-health-parity-addiction-equity

[6] Center for Medicaid & Medicare Services (CMS), September 2024, *Guidance SHO # 24-005 from regarding Best Practices for Adhering to Early. and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements:* https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf

[7] Center for Medicaid & Medicare Services (CMS) (September 2024) *Guidance SHO # 24-005 Best Practices for Adhering to Early. and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements*: https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf

The requirement or mandate for formal, eight—to ten-hour evaluations that include standardized testing measures (validated psychometric tools) such as the ADOS, is stealing crucial time from Ohio's children, who could be getting treatment for 15 to 18 months sooner instead of parked on a waitlist for one of these formal evaluations. Since the state would be applying this standard only to ASD, and we are concerned the state could be applying this standard only to ASD, we believe this may be a non-quantitative treatment limitation that would violate MHPAEA.

Family Impact: Many families with Medicaid coverage sit on very long waitlists, some up to 12 to 18 months, to get a formal, initial comprehensive diagnostic evaluation. Allowing autism symptom screenings and ADOS-only testing will enable families to immediately seek out treatment providers while getting on a waitlist for a formal, diagnostic.

Comment (C)(1)(b): We request the Department to allow ABA providers to diagnose and treat patients with ASD as long as they supply a list of other ABA providers in the area. Within the state's extensive provider network of community behavioral health centers (CBHC), diagnosticians diagnose and refer their patients to their services along with other providers in the community. We expect Ohio's ABA providers who employ diagnosticians to be treated the same, including what we find on the medical/surgical side of care. Not allowing this may be a non-quantitative treatment limitation that would violate MHPAEA.

Recommendation (C)(1)(c): We request the Department add the three paths below to the definition of allowable evaluations to help families start direct treatment sooner while waiting for a comprehensive diagnostic evaluation.

As a reminder, CMS' memo states that starting treatment services, including ABA, is based on medical necessity and by referral from a licensed practitioner within the practitioner's scope of practice, whether the child or youth has a formal, comprehensive diagnostic evaluation available for review or not. Also, some children or adolescents are extremely physically aggressive towards themselves or others, and it would not be appropriate or safe for the child or diagnostician to complete a standardized measure or psychometric tool.

1. Autism Specific Screening Tools –
    - Allow the results of autism screenings performed in primary care settings by trained, licensed practitioners in standardized autism-specific screening tools. If results indicate signs of autism, the family is then prescribed social, communication, and/or behavioral treatment recommendations.
2. Psychiatric Diagnostic Evaluation performed by Licensed Independent Behavioral Health Practitioners –
    - Allow this detailed assessment of a child's behavior and development, including complete, pertinent medical and social history, to diagnose or rule out ASD and other developmental disorders. The evaluation includes a neurodevelopmental review of cognitive, behavioral, emotional, adaptive, and social functioning *without* validated psychometric tools. 90791: Performed by mental health clinicians, no medical services.
    - Note: Licensed behavioral practitioners should be able to diagnose any mental health condition within the SM-IV: Diagnostic and Statistical Manual of Mental Disorders without requiring a standardized testing/psychometric tool. This type of evaluation is commonly used in other mental health conditions within CBH centers to then refer to services.
3. ADOS Only Evaluation –
    - Allow an Autism Diagnostic Observation Schedule (ADOS) only evaluation, is a standardized assessment tool for children and adults completed and signed by a trained, licensed behavioral health or medical professional or trainee working under the supervision of a licensed practitioner.
4. Comprehensive Diagnostic Evaluation (CDE) -
    - A CDE is a detailed assessment of a child's behavior and development, including complete, pertinent medical and social history, to diagnose or rule out ASD and other developmental delays. A comprehensive diagnostic evaluation includes a neurodevelopmental review of cognitive, behavioral, emotional, adaptive, and social functioning and necessitates the use of validated psychometric tools used to diagnose autism and related disorders and approved by the department.

Recommendation (C)(1)(c): We request the Department delete "comprehensive diagnostic evaluation" and replace it with "A completed evaluation as listed in (B)(1)".

Recommendation: We request the Department not require a re-evaluation for ASD after two to three years from the initial evaluation date. The ABS Assessment service (97151) would provide sufficient evidence of the presence of ASD symptoms and treatment goals to address them.

Concern (C) (2) (e): School attendance and educational documents are not considered in determinations.

The requirement of school documents and school schedules as part of the medical necessity determination process would not meet the standards of care for ABA and all other types of medical/surgical or behavioral health services. It would be considered a non-treatment limitation (NQTL) within mental health parity (MHPAEA) law.

Recommendation: Remove the language "school attendance"

Concern **Section (C) (2) (f)** Capacity for self-care and self-sufficiency to decrease interventions in the home

We agree that ABA treatment aims to help children learn to manage behaviors, communicate, and achieve new skills and achieve their best functioning. After the completion of treatment, the goal is to have more self-care and self-sufficiency and decrease interventions delivered by treatment staff in the home. However, reducing or ending treatment too early and replacing skilled intervention delivered by independent or dependent providers could be highly detrimental to the child's health and safety and substantially compromise future functioning and ability to ameliorate significant behavioral problems and skill deficits, especially as long as ABA continues to be medically necessary.

Recommendation: We request the Department remove "When applicable" and replace it with "After completion of treatment and mastery of skills,"

Consideration (C) (2) (4): Authorization of hours of treatment should not be limited to a monthly allocation of 97155.

Providers have recently experienced MCOs applying monthly caps on ABS protocol modification services (97155) and ABS with the protocol (97153). The approved six-month authorization for hours/units would now be divided into per-unit-per-month amounts. We also see a limitation of only 2 hours of assessment service (97151) per day which limits the BCBA/COBA/LIBHP from drafting notes and reports on the same day as the observation with the client present while all is fresh in memory. We need more flexibility, especially for more complex cases.

This monthly allocation cap can disrupt treatment supervision, especially when children miss treatment due to holidays, illness, client cancelations, or staff loss. The monthly allocation looks like a non-treatment limitation (NQTL) within mental health parity MHPAEA) law, applied to a specific condition, autism, only. Providers are not experiencing this in other treatment services delivered to individuals with autism, such as speech or occupational treatment services or ABA delivered in commercial insurance.

Recommendation: We request the Department consider adding "approved units of service should be delivered based on the individual's needs and not a per-month usage guideline applied to 97155 and 97153 for Adaptive behavior treatment ABS direct treatment as listed in (2)(a)(ii) in 5160-34-02. Assessment services 97151 should not be limited to two hours per day.

Concern (D) (2) (b): Service Plans issued by other Systems

Listing other treatment services from non-ABA providers as part of the child's prior authorization process is acceptable. However, if the parent chooses not to release specific "service plans," as the draft rule states, it should not stop the medically necessary process from continuing based on their patient rights. An independent practitioner cannot force the parent or another service provider to communicate or share records, nor can they force a parent or guardian to provide consent to coordinate care or obtain records.

If the child receives services from a Community Behavioral Health Center (CBHC) during the care coordination process, the ABA provider can confirm ABA services are only delivered within the 9000 codes and not delivered by the CBHC.

Family Impact: Detailed plans from other systems would not impact a child having a prescription from a licensed practitioner for behavioral treatment for ASD; it could delay treatment starting, which could be detrimental to the child.

Recommendations: We request the Department delete the requirement for the ABA provider to obtain service plans issued by other systems. The coordination of care process can continue whether or not the ABA provider has the other system's service plans.

Concern (D) (3) (d): **Documentation of Parent or Caregiver's Participation**

The parent or caregiver's participation should be noted, as appropriate, during a direct billable one-on-one or group family adaptive behavior treatment guidance session progress note.

Family Impact: The assessment, treatment plan, and prior authorization request should make clear the realities of daily life and considerations facing the child's parents or caregivers when attending and participating in treatment.

Recommendation: We request the Department delete "ABA treatment" and replace it with "family treatment guidance." Also, a progress note explaining why a parent did not attend each scheduled session should not be required because no service was delivered.

Concern (E) (2): Limitations: Indirect and Direct Supervision Limitation Not listed in this Chapter

We are not clear on the meaning of "in this Chapter." We agree that supervision is delivered based on the medical necessity process, the ABA standards of care, The Practice Guidelines, and the BACB's (certifying board of BCBAs and RBTs) supervision requirements for maintaining an RBT certification.

For patient case supervision called ABS with protocol modification (97155), the BACB recommends 20% of the technician billable hours. Still, most of these services are usually provided between 10% and up to 20%, if medically necessary, of authorized treatment hours. The BACB requires the RBT to receive 5% supervision from the BCBA/COBA.

Recommendation: We request the Department delete the word "Chapter" and add "of the BACB RBT supervision requirement of 5% and the industry's standards of care for patient case supervision.

Concern (E (3): Limitations: Not for Recreational or Educational Outcomes

As children achieve positive outcomes under their authorized ABA treatment plan, we expect to see increased positive outcomes in all areas of their lives. A child can receive ABA treatment while engaging in activities such as playing at a park, attending a dance class or sporting event, using the library, or attending daycare or preschool.

The ABA provider works only on the insurer's authorized behavioral treatment goals listed on the child's treatment plan.

These environments offer important real-world interaction opportunities with non-family members and neurotypical peers to work on goals commonly found in authorized ABA treatment plans. These goals include social interactions, relationship building, boosting confidence, practicing calming and preventative behavioral strategies, and communication. We understand there may be times during these activities when a treatment plan goal or intervention is not being worked on, and that time would not be billable.

ASD is a global developmental disorder involving impairments in social interaction, communication, and behavior, and children with ASD frequently have difficulty generalizing behaviors across settings. Because of this and because the primary evidence-based treatment for ASD, ABA, involves the interaction between behavior and environment, it is medically necessary for some children with ASD to receive behavioral health treatment across a variety of settings, including parks, stores, restaurants, and school settings, to treat their condition and achieve maximum functioning successfully.

Family Impact: Each activity listed above, along with many others, is crucial in a child's development and well-being and essential to the child and the family as they live with autism.

Recommendation: We request the Department allow ABA treatment to be delivered in environments and settings where we naturally find children, teens, and young adults that will support them in learning, maintaining, and mastering skills to reduce symptoms of ASD and achieve their maximum functioning. This would better align with the recent CMS guidelines noted above.

Concern (E)(7): Duplication of Services Authorized Under Another Medicaid Service.

Please see this addressed under Concern (C) (2) (c): Lack of clarity on Community Behavioral Health Centers (CBHC) ability to deliver ABA and Concern (D) (2) (b): Service Plans issued by other Systems.

Recommendation: We request the Department delete (E)(7).

Comment (F) (1): Appendix for Allowable Locations of Service Delivery

The appendix for allowable service locations was not provided in the draft rules. We requested this information from the Department. We want to share the following two resources and our comments under Concern (E (2): Limitations: Not for Recreational or Educational Outcomes.

CMS recent guidelines: *"Consistent with federal disability rights laws and the Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), states must ensure that services covered under EPSDT are provided in the most integrated setting appropriate for the child, which includes clinics, or in schools, and at home, and must avoid unnecessary placements in segregated treatment settings.157F 158, 158F 159 As children should be cared for in the most integrated setting appropriate for their needs, inpatient and residential levels of care must not be the default treatment setting, either explicitly or because of a lack of capacity of services offered in integrated settings, including for children and youth with severe needs, and should be reserved for children with acute needs on a short-term basis.159F 1"* [8]

[8] Center for Medicaid & Medicare Services (CMS) (9-2024) ,Page 42, *Guidance SHO # 24-005 Best Practices for Adhering to Early. and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements*: https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf [8] https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf

Standards of care for ABA within CASP Practice Guidelines. *"ABA treatment must not be restricted a priori to specific settings but instead should be delivered in the settings that maximize treatment outcomes for the individual patient. It may be medically necessary for a patient to receive services in a particular location for a variety of reasons, including but not limited to generalization needs, the impact of interactions in this environment on skill building or behavioral targets in the treatment program, or to access the required intensity of services for the patient. For example, treatment in various community settings such as daycare, school, or a recreational activity may be medically necessary to promote social–emotional reciprocity, nonverbal communicative behaviors, and the development and maintenance of relationships. Treatment should not be denied or withheld solely because a caregiver can or cannot be present at the treatment location."*

Family Impact: Concern (E (2): See Recommendation on Limitations: Not for Recreational or Educational Outcomes.

Recommendation: <u>If the location appendix does not include locations other than home, clinic, and community, we request that the Department add recreational, school, daycare, and preschool settings.</u>

Comment F. (1) & (2): Reimbursement Rates, Hospital Reimbursement for ABA, & Concurrent Billing

Our Coalition applauds the Department and Milliman for the detailed actuarial analysis process and for setting rates broadly consistent with publicly available national averages across other state Medicaid programs. The announced draft reimbursement rates align with the Coalition's cost survey results shared with the Department.

We have seven comments on reimbursement rates and request the Department consider the following:

1. CPT Codes 97152 and 0362T are $4 and $3 lower than the national state Medicaid reimbursement average per 15-minute unit, respectively.
    a. Recommendation F. (1): <u>Increase reimbursement for 97152 and 0362T by at least $2 per 15-minute unit.</u>
2. BCBA/COBA/LIBHPs need distinct reimbursement when delivering direct treatment (97153). Some children may receive ABA treatment services for a minimal number of treatment goals that can be delivered by BCBA/COBA/LIBHPs directly and without needing direct care staff such as Technicians. The HO modifier can be used on claims from the BCBA/COBA/LIBHP. Since most of these services will occur in the home, with travel costs, and without Technicians delivering services, we need the increase to cover the cost.
    a. Recommendation F. (1): <u>Reimburse 97153 when delivered by a BCBA/COBA/LIBHP by increasing to the national average within Medicaid fee schedules for 97153 HO to $106.64 per hour or $26.66 per unit.</u>
3. After signing the MCO's provider contract stating they follow the Medicaid reimbursement fee schedule, some providers have seen their reimbursement rates for speech and occupational treatment cut by 15%. It would not be acceptable if ABA reimbursement rates were decreased.
    a. Recommendation F. (1): <u>Do not allow MCOs to reduce reimbursement for ABA and ensure they pay the Medicaid-approved fee schedule.</u>
4. CPT Code 0373T - For a few, rare cases when a child needs 0373T Adaptive Behavior Treatment with Protocol Modification but also needs the Independent ABS Provider (BCBA/COBA/LIBHP) to be present in treatment creating a 3 to 1 ratio to maintain safety for all, we would like an opportunity to add a complexity modifier such as KX in CBHC services.
    a. Recommendation: <u>Increase reimbursement of 0373T $45.54 per 15 minute unit when a complexity code is utilized.</u>

5. Hospital rates are set as a per diem (daily) reimbursement rate when delivering ABA in an outpatient setting and are significantly lower than the newly announced draft ABS 9000 15-minute unit codes.
    a. Recommendation F. (2): Increase EAPG reimbursement for ABA delivered in hospital outpatient settings to align with new draft reimbursement rates for ABS.
    b. Recommendation: Allow telehealth delivery of ABA for hospital providers for all ABS CPT codes except 0373T, especially 97156 ABS Guidance.
6. Inflationary increases every three years would help providers cover the cost of inflationary business expenses.
    a. Recommendation F. (1): Consider an inflationary increase every 3 years to help ensure reimbursement keeps up with increased costs year to year.
7. Allow Co-Treating between speech, occupational, and physical treatment and ABA providers for children with ASD that are not driving treatment outcomes in SP/OT/PT services due to significant maladaptive behaviors.
    a. Recommendation F. (1): Allow co-treating between SP/OT/PT treatments and ABA services when deemed medically necessary for a limited period of time.

Comment (F) (1): Concurrent Billing for some Adaptive Behavior Service (ABA) CPT Codes

We wanted to share that the following Adaptive Behavior Service (ABA) CPT Codes can be billed concurrently or at the same time per the American Medical Association (AMA) CPT 2019 Code Set[9] coding

As long as the criteria for both codes are met, CPT codes 97153 and 97155 may be billed concurrently, along with:

- 97151 with 97153, 97154, 97156 (without patient present), 97157, 97158, 0373T
- 97153 with 97155, 97156 (without the patient present), 97157, 97158
- 97154 with 97155, 97156 (without the patient present), 97157, 97158

Recommendation: We request the Department add a note to the ABA/ABS Medicaid fee schedule indicating codes that can be concurrently billed for transparency.

On behalf of the Coalition's 48 engaged ABA providers, our families, and stakeholders. we thank you for reviewing and considering our comments. If you have any questions or if I can serve as a resource to ODM, please do not hesitate to contact Marla Root, Founder & CEO of Ohio Autism Insurance Coalition, at phone 614-565-5765 or email Help@ASDOHIO.com. Again, we are very appreciative of the Department's efforts in these proposed rules.

[9] *CPT Assistant November 2018/Volume 28 Issue 11*, American Medical Association (AMA) CPT 2019 Code Set, https://commerce.ama-assn.org/store/ui/catalog/productDetail?product_id=prod270004&navAction=push