

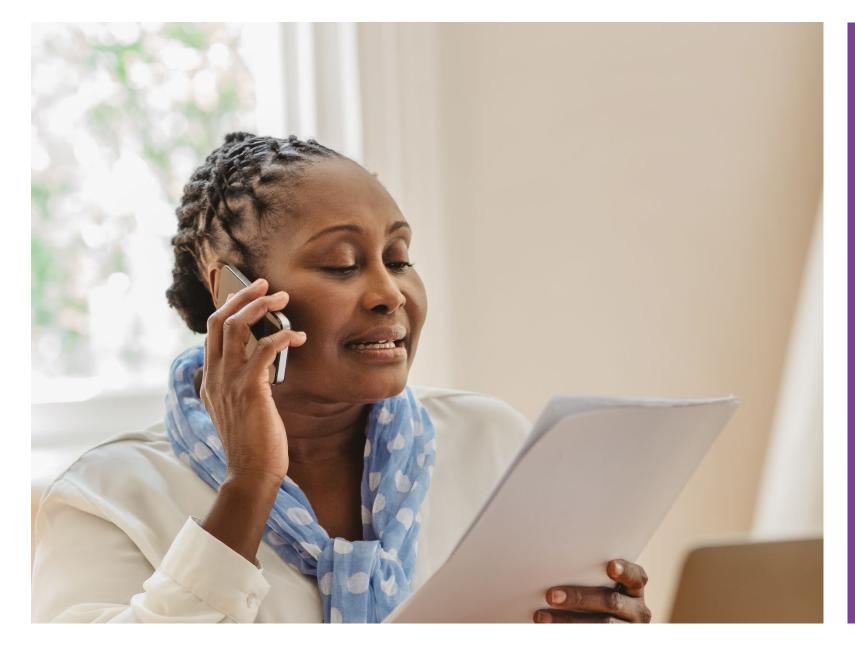
Applied Behavioral Analysis (ABA) Providers



ABA CPT Codes, Modifiers, and Locations

ABA Codes		Modifier	Modifier	Modifier	Modifier	Location Codes
Green Requires Auth (97155 auth for all)	Description	None (RPT/UBT)	HN (Bachelors LABA)	HO (Master's LBA)	TF (Other LMHP)	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)
0373Т	Treatment: Team Analysis & Treatment, Modified Treatment		~	√	~	✓ (not 03)





Authorizations – 97155

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

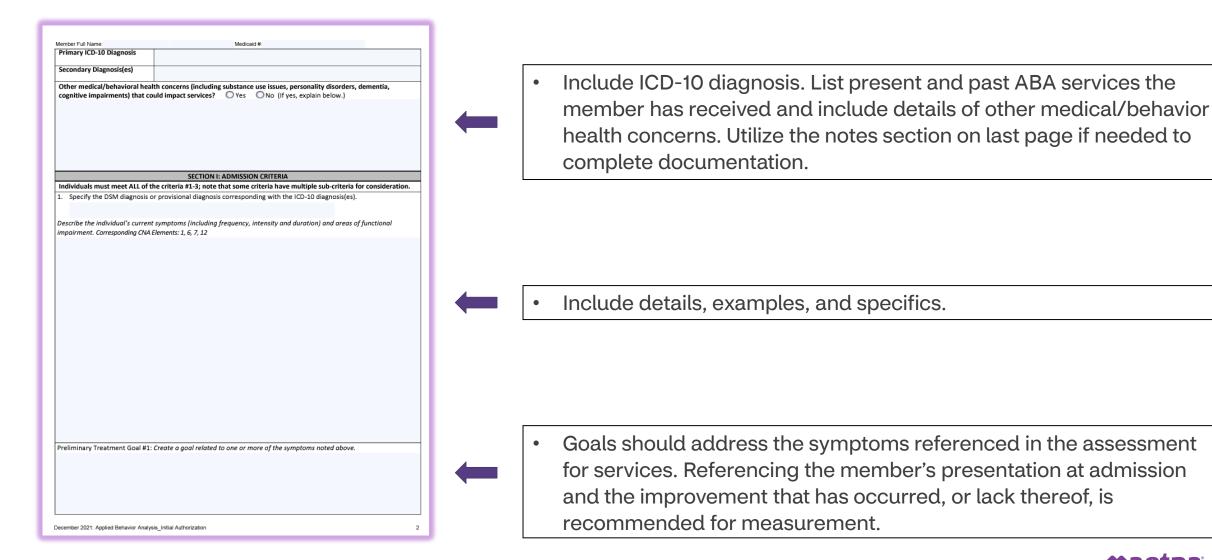




BRAVO VIORAL HEALTH REDESIGN			DMAS
CCESS, VALUE & OUTCOMES	THE DEPARTMENT OF MEI	DICAL ASSISTANCE SERV	/ICES
	Applied Behavior An	alysis (97155, Et	al.)
<u>!</u>	NITIAL Service Autho	rization Request	Form
Needs Assessment (CNA) are re	elevant and can be used for efficie	ency. For all requests excee	on obtained during the Comprehens eding 20 hours (80 units) or more p chedule of activities used to structo
	be how the activity will facilitate t		
Member First Name:	NFORMATION	Organization Name:	ER INFORMATION
Member Last Name:		Group NPI #:	
Medicaid #:		LBA/LMHP NPI #:	
Member Date of Birth:		Provider Tax ID #:	
Gender:	-		
Member Plan ID #:		Provider E-Mail:	
Member Street Address:		Provider Address:	
City, State, ZIP:		City, State, ZIP:	
		Provider Fax:	
Member Phone #:		Clinical Contact Name and Credentials*:	
Parent/Legal Guardian Name (s):		Phone #	
Parent/Legal Guardian Phone #:			om the MCO can reach out to in onal necessary clinical informatio
	Request for App	proval of Services	
Retro Review Request? (Yes O No		
If the member is currently pa	rticipating in this service, start	date of service:	
Proposed/Requested Service	Information:		
	44		
From (date), To _	(date), for a total of	units of serv	rice.
Plan to provide hou	rs of service per week.*		
	0 units) or more per week, submit the sch on of the behavioral modification plan.	edule of activities used to structur	e the service sessions and describe how the
	t periods of Applied Behavior A requesting provider in the past		rapy) that have been provided b
Provider	Dates of	Outcomes	
	Service/Intervention		
	•	-	

- 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.







2 \//	thin the past 30 calendar days, the youth has demonstrated at least two of the following:	
	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
	Criterio I.	○ No
Prelim	inary Treatment Goal #2A: Create a goal related to the difficulties with communication.	
В.	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.	O Yes
		O No
	inary Treatment Goal #2B: Create a goal related to the difficulties in social interaction, reasoning, recip	rocity and
interp	rsonal relatedness.	

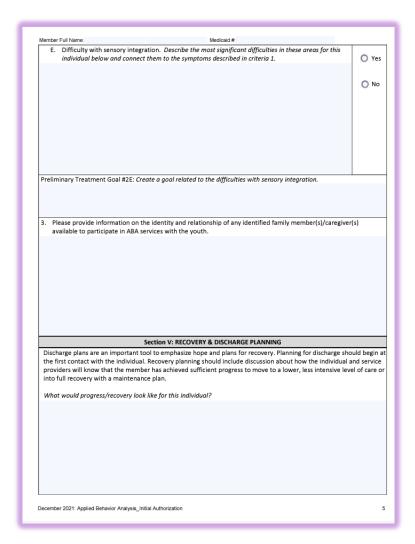


 Complete all sections of each page.



	Full Name: Medicaid #:	
C.	Frequent intense behavioral outburst 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.	O Yes
		○ No
relin	inary 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.	O Yes
		O No
	inary Treatment Goal #2D: Create a goal related to the difficulties with disruptive, obsessive, repetitive zed behaviors.	or

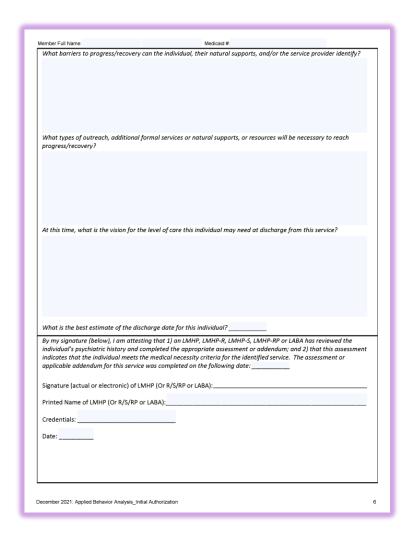






- Discharge planning should begin at intake.
- · Always include an estimated date of discharge.
- Placing "unknown" is acceptable; however, blank submissions are considered incomplete.







- 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.

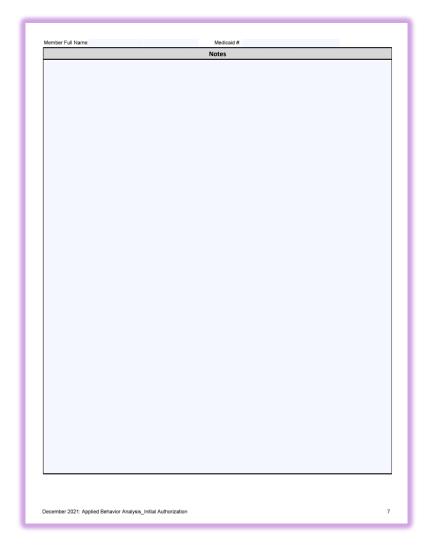


X John Smith

X John Smith

X John Smith





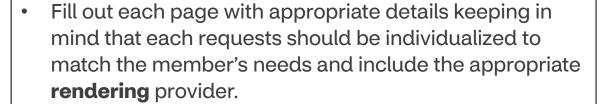


- This section can be utilized in a multitude of ways.
- You may reference sections above in the document where you may not have had enough space to clinically document.
- You may also use this space to provide a narrative of symptoms and behaviors, or how the member continues to meet medical necessity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



MHS Applied Behavior Health Continued Stay

	navior Analysis (97155, Et al.)
For all requests exceeding 20 hours (80 units	Y Service Authorization Request Form) or more per week, please submit with (or write in note section) the service sessions and describe how the activity we modification plan.
MEMBER INFORMATION	PROVIDER INFORMATION
Member First Name:	Organization Name:
Member Last Name:	Group NPI #:
Medicaid #:	LMHP/LBA NPI #
Member Date of Birth:	
Gender:	Provider Tax ID #:
Member Plan ID #:	Provider Phone:
Member Street Address:	Provider E-Mail:
City, State, ZIP:	Provider Address:
	City, State, ZIP:
Member Phone #:	Provider Fax:
Parent/Legal Guardian	Clinical Contact Name and Credentials*:
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
Regu	est for Approval of Continued Services
riequ	



• 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 <u>DMAS Provider Services</u>
 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





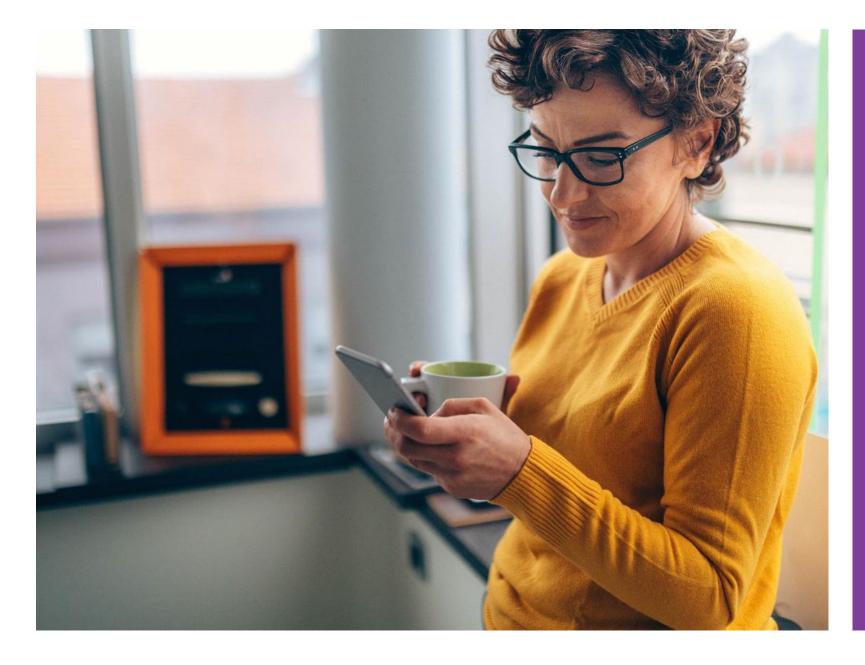
Submitting ABA Claims



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**.
- 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 <u>DMAS Mental Health Services</u> <u>Appendix D</u>.
- 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 <u>training</u> for <u>services</u> 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
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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
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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 1-833-459-1998.
 - o If you are not satisfied with the Peer-to-Peer result, you will be able to submit a formal appeal with Aetna. 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 Dr.
 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 or procedure
- Service/admission date
- Location of treatment

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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