Clinical Policy: Applied Behavioral Analysis Documentation Requirements

Reference Number: CP.BH.105
Date of Last Revison: 02/26

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Applied Behavior Analysis (ABA) services must meet specific documentation requirements and adhere to applicable regulations, accreditation standards, and professional practice standards. Appropriate and accurate documentation is critical to providing member/enrollees with quality care, treatment planning, and progress monitoring. It helps facilitate communication with all team members participating in the plan of care, ensuring appropriate utilization reviews and regulatory reimbursement compliance.[1]

***Note**: All documentation submitted must be clear and legible.*

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that, when a covered benefit, clinical documentation for Applied Behavioral Analysis (ABA) services contains all the following:
***Note:** Billed units not fully supported by documentation may be subject to payment denial or recoupment.*

A. Prior authorization approval for ABA services has been obtained, if required;
B. Clinical documentation is reviewed and updated at regular intervals and includes the signature and printed names of the member/enrollee, legal guardian, rendering clinician/technician and supervising practitioner/Qualified Healthcare Provider (as applicable);
C. Documentation and data collection supports that active treatment was delivered throughout the duration of billed services as evidenced by both of the following;
   1. Continuous and efficient use of session time that is clinically justified and consistent with treatment plan goals;
   2. The full session duration consisted of active treatment components with minimal non-programmed or idle time;
      ***Note**: Activities that do not constitute active session engagement include, but are not limited to:*
      - *Unstructured or non-therapeutic periods (e.g., meals not embedded with documented teaching, free play not embedded with documented teaching).*
      - *Administrative tasks or documentation completed outside of direct intervention.*
      - *Periods without documented data collection or documented therapeutic interaction addressing specific treatment goals.*
D. Service activity notes for all services rendered are completed prior to claim submission and include all the following:
   1. Identification information including all the following:
      a. Name of provider organization, and rendering provider or technician, clearly visible at the top of each note;

   b. Member/enrollee's name, listed on each page;
      ***Note**: If the legal name differs from the preferred name, the legal name is noted at the top of the note. The preferred name should be noted in parentheses and used in the rest of the documentation.*
   c. Date of birth (DOB) or unique identifier (UI);
2. Exact date and time of session to include start and end time;
3. If the date the note was created was different than the date of service, the note includes the date of note creation with rationale for why note was created on a date different than the service was rendered;
4. Pauses in services (indicating the exact time the service was paused and the time it resumed);
5. Location of services;
6. Type of service provided, with applicable code;
7. Signature of qualified rendering provider/technician;
8. Summary of treatment activity, includes all of the following:
   a. Member/enrollee's current clinical status, including presenting symptoms;
   b. Primary target areas addressed;
   c. Summary of techniques used during the session;
   d. Direct treatment provided;
   e. If applicable, barriers to treatment plan implementation and how they were addressed;
   f. If the following services are rendered: 0373T, 97155, H0032 and/or 97158, all the following:
      i. List of protocol modifications made, or a clear rationale indicating that no modifications were needed. The rationale for no modification must include the protocol components reviewed and the clinical justification for maintaining the current protocol;
      ii. Protocol modification occurs for at least two hours per week or 10% of the direct service hours provided, whichever is greater, and no more than 20% of direct service hours provided (unless clinical documentation justifies);
      iii. At least monthly one-on-one service delivery with member/enrollee to develop new or modified protocol (or clinical review with justification for why no modifications are needed, as noted above) (97155, H0032), meeting all the following:
         a) Rendered by ABA supervisor;
         b) Not delivered via telemedicine/telehealth unless allowed by state guidelines;

         Note:
         - 97155 may be used to demonstrate new or modified protocol to a technician with the member/enrollee present. Technician supervision only or team meetings do not constitute protocol modification.
         - All 97153/97154 units billed for the member/enrollee for the entire six-month authorization period that are not supported by the requirements for protocol modification, as specified in I.D.8.f., are subject to denial of payment or recoupment. For example, if protocol modification amounts to 7% (7 hours billed), on average for the authorization period, of 100 hours

billed for 97153/97154, 30% of 97153/97154 hours billed (30 hours) for that authorization period were not supported by 10% protocol modification (3 hours of protocol modification was expected but not billed) and payment will be denied or recouped for the 30 hours.

iv. Direction of technician (applicable to 0373T and may be applicable to 97155 and H0032);
v. Direct observation of rendering provider (applicable to 0373T, 97155 and H0032);

g. If caregiver training occurs (97156 or 97157), caregiver participation and/or identification of barriers to caregiver engagement and plan to address the barriers;
***Note**: Caregiver signature is recommended on clinical notes documenting their participation.*
h. If services are delivered via telehealth, the platform complies with HIPAA privacy and security standards, and the rendering provider/technician had their camera turned on and functioning audio output/input;
i. Progress, or lack of, towards the identified treatment goals (includes cumulative graphs of goals and objectives and baseline data, as applicable);
***Note**: Lack of documented progress must be accompanied by clinical rationale and evidence of treatment plan adjustment (under 97155/H0032).*
j. Member/enrollee's response to treatment, and the outcome of the interventions;
k. Identification of all individuals who actively participated in the sessions, to include the relationship with the member/enrollee;
***Note**: PHI or PII data for non-member/enrollees should not be included.*
l. Coordination of care.

9. Addenda created to supplement documentation after the completion of the original clinical note include the following (as applicable):
***Note**: Addenda are intended to clarify or correct existing documentation and not substantively modify the nature, duration, or content of services rendered.*
a. Clear reference to the original clinical note being supplemented;
b. Date of note completion;
c. Legible name, signature, and credentials of rendering clinician/technician;
10. Discharge planning is documented in all treatment plans and upon termination of services.

II. It is the policy of health plans affiliated with Centene Corporation that, when a member/enrollee no longer meets medical necessity criteria for Applied Behavioral Analysis (ABA) services, a discharge summary includes all the following documentation requirements (as applicable):
A. Referrals provided;
B. Rationale/reason for discharge, with support in progress summary;
C. Signature of qualified rendering provider;
D. Signature of caregiver;
E. Date of discharge.

Background

Documentation of ABA treatment services is essential to demonstrate medical necessity, active treatment, and progress towards addressing the member/enrollee's individualized treatment goals. Accurate and timely documentation supports continuity of care, facilitates collaboration, and ensures compliance with regulatory state requirements.

According to the Council of Autism Service Providers (CASP), the following are considered the *core characteristics* of Applied Behavioral Analysis (ABA) and should be apparent throughout all phases of assessment and treatment:

1. Objective assessment and analysis of the person's condition by observing how the environment affects their behavior, as evidenced through appropriate measurement.
2. Understanding the context of the behavior and the behavior's value to the person, their caregivers, their family, and the community.
3. Promotion of the person's dignity.
4. Utilization of the principles and procedures of behavior analysis to improve the person's health, skills, independence, quality of life, and autonomy.
5. Consistent, ongoing, objective data analysis to inform clinical decision making.

The following are *essential practice elements* of ABA:

1. A comprehensive assessment that describes specific levels of behavior(s) at baseline and informs the subsequent establishment of meaningful treatment goals.
2. An emphasis on understanding the current and future value or social importance of behavior(s) targeted for treatment.
3. Reasonable efforts toward collaboration with the person receiving treatment, their guardians if applicable, and those who support them (e.g., caregivers, care team) in developing meaningful treatment goals.
4. A practical focus on establishing small units of behavior that build toward larger, more significant changes in abilities related to improved health, safety, skill acquisition, and/or levels of independence and autonomy.
5. Collection, quantification, and analysis of direct observational data on behavioral targets during treatment and follow-up to maximize and maintain progress toward treatment goals.
6. Design and management of social and learning environment(s) to minimize challenging behavior(s) and maximize the rate of progress toward all goals.
7. An approach to the treatment of challenging behavior that links the function(s) of, or the reason(s) for, the behavior with programmed intervention strategies.
8. Use of a carefully constructed, individualized, and detailed behavior-analytic treatment plan that utilizes reinforcement and other behavioral principles and excludes methods or techniques not based on established behavioral principles and theory.
9. Use of treatment protocols that are implemented repeatedly, frequently, and consistently across environments until discharge criteria are met.
10. An emphasis on frequent, ongoing analysis and adjustments to the treatment plan based on patient progress.
11. Direct training of caregivers and other involved laypersons and professionals, as appropriate, to support increased abilities and generalization and maintenance of behavioral improvements.

12. A comprehensive infrastructure for case supervision by a behavior analyst of all assessments and treatment.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Providers should reference the most recent version of ABA Coding Coalition for information on Medically Unlikely Edits (MUEs), and related processes for code usage and descriptors. The Centers for Medicare & Medicaid Services guidelines should be used to determine the maximum units of service a provider can report under most circumstances during a single date of service.[6]

CPT®* Codes	Description
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
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 one patient, each 15 minutes
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
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
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
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
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

CPT®* Codes	Description
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
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 two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior
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 two or more technicians; for a patient who exhibits. destructive behavior: completion in an environment that is customized to the patient's behavior

HCPCS®* Codes	Description
H0031	Mental health assessment, by nonphysician
H0032	Mental health service plan development by nonphysician
H0046	Mental health services, not otherwise specified
H2012	Behavioral health day treatment, per hour
H2014	Skills training and development, per 15 minutes
H2019	Therapeutic behavioral services, per 15 minutes
S5110	Home care training, family; per 15 minutes
S5111	Home care training, family; per session

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed	11/23	11/23
Annual review. Policy restructured and reformatted to remove redundant information and clarity in documentation requirements throughout. Added inclusive language to allow for a variation of state allowances throughout the policy. Removed comprehensive assessment report criteria and replaced it with I.C. “Comprehensive diagnostic evaluation, consistent with state defined ABA criteria. Defined service documentation requirements, which are note listed as I.D.1., Behavior assessment, I.D.2., Initial treatment record requirements and I.D. 3. Continuation treatment records. Summarized treatment plan criteria and listed under the initial treatment records in I. D.2. Service activity note requirements are listed under I.E. Added Policy statement II to document discharge summary requirements if member/enrollee no longer meets medical necessity criteria. Background section reviewed and updated. References reviewed and updated. In the important reminder section, changed “medical necessity” to “documentation” in the statement “The	12/24	12/24

Reviews, Revisions, and Approvals	Revision Date	Approval Date
purpose of this clinical policy is to provide a guide…" because this is not a medical necessity policy.		
Annual review. Policy restructured and reformatted. Added a note to the description indicating all documentation must be clear and legible. Removed medical necessity criteria noted in former I.A-D and provide clarity in documentation requirements throughout. Added I.A. " Prior authorization approval...". Added I.B. "Clinical documentation is reviewed and updated...". Added I.C. "Documentation and data collection...". Added a note to I.C. with examples of non-active engagement. In I.D.1-7 combined service note requirements for all services rendered by RBT and QHP. In I.D.8.a-e added new criteria to expand requirements for a detailed summary of treatment activity. I.D.8.f.and g. added documentation guidance when services associated with CPT codes 0373T, 97155, 97158, 97156 and 97157 are rendered. Added I.D.8.h. regarding telehealth requirements. Added I.D.8.i. "Progress or lack of..." Added I.D.8.j. "Member/enrollee's response...". Added I.D.9. "Addenda created to include additional documentation after the initial submission...". Added I.D.10. "Discharge planning...". Added II.C." Signature of qualified rendering provider." Added I.D. "Signature of caregiver." Background updated. References reviewed and updated.	11/25	11/25
Ad hoc review. Added a note to policy statement I. "Billed units not fully supported...". Added code "H0032" to I.D.8.f. Added new I.D.8.f.ii. "Protocol modification occurs...". Added code "H0032" to I.D.8.f.iii. Removed former I.D.8.f.ii.c). " does not exceed eight units (two hours) per day". Added additional statement to the note associated with I.D.8.f.iii. "All 97153/97154 units billed for the member/enrollee for the entire six-month authorization period that are not supported by the requirements for protocol modification, as specified in I.D.8.f., are subject to denial of payment or recoupment..." Added code "H0032" to I.D.8.f. iv. and v. In I.D.8.h. added HIPAA compliance verbiage. Background updated. Added HCPCS codes "H0031, H0032, H0046, H2012, H2014, H2019, S5110, S511". References reviewed and updated.	02/26	

References

1. Behavioral Health Center of Excellence – 101 Standard for the Documentation of Clinical Records for Applied Behavior Analysis Services. https://www.bhcoe.org/standard/bhcoe-standard-101-standard-for-the-documentation-of-clinical-records-for-applied-behavior-analysis-services/. Published November 23,2020. Accessed February 10, 2026.
2. The Council of Autism Service Providers (CASP) Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers, 3rd Edition. https://www.casproviders.org/standards-and-guidelines#practiceguidelines. Updated April 29, 2024. Accessed February 10, 2026.

3. Department of Defense (DoD). TRICARE. Comprehensive Autism Care Demonstration. Website. https://www.tricare.mil/Plans/SpecialPrograms/ACD. Updated December 22,2025. Accessed February 10, 2026.
4. Behavioral Health Center of Excellence – 201 Standard for the Documentation of Clinical Records for Applied Behavior Analysis Services. https://www.bhcoe.org/standards/. April 1, 2025. Accessed February 10, 2026.
5. The Council of Autism Service Providers (CASP) Practice Parameters for Telehealth-Implementation of Applied Behavior Analysis, 2nd Edition. https://assets-002.noviams.com/novi-file-uploads/casp/pdfs-and-documents/Final-Copy-Practice-Parameters-Telehealth-ABA-AMA-References-12_2_2199-eb8b6cb1.pdf. Updated December 1, 2021. Accessed February 10,2026.
6. ABA Coding Coalition Model Coverage Policy for Adaptive Behavior Services. https://abacodes.org/wp-content/uploads/2022/01/Model-Coverage-Policy-for-ABA-01.25.2022.pdf. Updated January 2022. Accessed February 10, 2026.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide documentation guidance, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise

professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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