Applied Behavior Analysis Co-signature Requirements

Best Practice and Legal Considerations

AUTISM LEGAL RESOURCE CENTER

CASP The Council of Autism Service Providers

Applied behavior analysis (ABA) is the generally accepted standard of care for the treatment of autism spectrum disorder (ASD). Coverage is required in commercial insurance and Medicaid plans in all 50 states.

The Council of Autism Service Providers (CASP) is the recognized non-profit, international trade association for autism service providers, establishing best practice guidelines and generally accepted standards for delivering ABA services for the treatment of ASD.

These include CASP's Applied Behavior Analysis Practice Guidelines for the Treatment of Autism Spectrum Disorder, *Practice Parameters for Telehealth Implementation of Applied Behavior Analysis*, and industry standard documentation templates for ABA service delivery.

Recently, there has been confusion about whether direct treatment session notes (for services typically provided by behavior technicians under CPT® Codes 97153 and 97154) require a co-signature by the supervising Board Certified Behavior Analyst® (BCBA®).

Some funders have maintained that this is a standard documentation requirement and that it stems from application of the "incident to" doctrine, which applies when ancillary personnel provide *incidental* services that are integral to *professional* services billed by certain health care practitioners.

As discussed below, the "incident to" doctrine does *not* apply to direct treatment services provided by behavior technicians. In accordance with applicable professional standards of service delivery and AMA CPT® codes, such counter-signatures are not part of industry documentation standards for ABA.

Although co-signatures are not required, and therefore their absence does not indicate deficient documentation, funders may—with appropriate notice and to the extent allowed by law—include a co-signature requirement as a contractual obligation.

Co-signatures are not required by industry standards

Elements for billing "incident to" service

The "incident to" concept is a feature of the Medicare program and typically applies where auxiliary office personnel are assisting physicians and/or other qualified health care providers in their provision of in-office services.[1]

> "Incident to" billing allows for billing a non-physician practitioner's services as though they were being provided by the physician. The services are reimbursed under the physician's billing code at the full physician rate, rather than the percentage rate typically allowed to the work of non-physician practitioners. The auxiliary office personnel are not performing discrete billable services. Instead, they are assisting the physician in the performance of his or her in-office physician services.[2] As set forth in the Medicare Benefit Policy Manual: "*Incident to a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness.*"[3]

For the "incident to" doctrine to apply, the auxiliary personnel delivering services must be directly supervised by the physician/QHP, who must be present in the office and immediately available to provide direct supervision throughout the auxiliary personnel's performance of the service. As also set forth in the Medicare Benefit Policy Manual:

"*B - Direct Personal Supervision*

Coverage of services and supplies incident to the professional services of a physician in private practice is limited to situations in which there is direct physician supervision of auxiliary personnel. Auxiliary personnel means any individual who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician.

---

[1] The services are "commonly provided without charge or included in the physician's or other listed practitioner's bill." Incident to Services & Supplies, CMS.gov, available at https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/advanced-practice-providers/incident-services-supplies

[2] See *Generally* Medicare Benefit Policy Manual ("Medicare Manual"), Chapter 15, Covered Medical and Other Health Services, Section 60, available at https://www.cms.gov/medicare/prevention/prevntiongeninfo/downloads/bp102c15.pdf; Incident to Services & Supplies, CMS.gov, supra; AAPC Knowledge Center 7 Incident-to Billing Requirements, available at https://www.aapc.com/blog/44912-seven-incident-to-billing-requirements/?srsltid=AfmBOooVuPdh2ZT2wFN5fJJW7ng391ul3D5VtOtN75ZvP-h1HhZRRnVG

[3] Medicare Manual, Section 60.1

Likewise, the supervising physician may be an employee, leased employee or independent contractor of the legal entity billing and receiving payment for the services or supplies.

However, the physician personally furnishing the services or supplies or supervising the auxiliary personnel furnishing the services or supplies must have a relationship with the legal entity billing and receiving payment for the services or supplies that satisfies the requirements for valid reassignment. As with the physician's personal professional services, the patient's financial liability for the incident to services or supplies is to the physician or other legal entity billing and receiving payment for the services or supplies. Therefore, the incident to services or supplies must represent an expense incurred by the physician or legal entity billing for the services or supplies. Thus, where a physician supervises auxiliary personnel to assist him/her in rendering services to patients and includes the charges for their services in his/her own bills, the services of such personnel are considered incident to the physician's service if there is a physician's service rendered to which the services of such personnel are an incidental part and there is direct supervision by the physician…

Direct supervision in the office setting does not mean that the physician must be present in the same room with his or her aide. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing services."[4]

These same principles apply to private insurers who have adopted the "incident to" billing procedure.[5]

"Incident to" billing does not apply to a behavior technician's provision of ABA adaptive behavior direct treatment services

Unlike "incident to" services, 97153 technician services are discrete billable services intended to be provided by behavior technicians. "Incident to" billing addresses services that are incidental to QHP services in the course of diagnosis or treatment of an injury or illness.

Adaptive behavior services—specifically the services associated with Current Procedural Terminology (CPT®) codes 97152, 97153, or 97154 or equivalent—are not incidental services; they are distinct, independent services of their own. Moreover, these codes were written with the understanding and intent that (in the overwhelming majority of cases) the services would be provided exclusively by technicians, not BCBA®-QHPs.[6]

---

[4] *Id.*

[5] See, e.g., Anthem, Commercial Reimbursement Policy, C-11002, "Incident to" Services – Professional, available at https://files.providernews.anthem.com/4840/Incident-to-Services-and-Billing-BCBS-CB-05082024.pdf

[6] American Medical Association, CPT® Assistant, November 2018, Volume 28, Issue 1, p. 5 (97153: Adaptive behavior treatment by protocol administered by behavior technician under the direction of a physician or other qualified health care professional; 97154 Group adaptive behavior treatment by protocol administered by behavior technician under the direction of a physician or other qualified health care professional); ABA Coding Coalition Supplemental Guidance on Interpreting and Applying the 2019 CPT® Codes for Adaptive Behavior Services, pp. 4-5 (CPT® Codes 97153 and 97154).

ABA behavior technician services are delivered under the "direction" of the QHP. That's a different type of oversight than the "supervision" applicable to "incident to" services. Professional standards and Adaptive Behavior Service codes deliberately use language that distinguishes technician services delivered under the "direction" of QHP from the "supervision" oversight involved in "incident to" services.

When the American Medical Association (AMA) established the Adaptive Behavior Service code set, the AMA specifically developed CPT® code 97155 and 97158 to include a definition referencing the direction of the technician(s). The word selection was designed to prevent the requirements of these new codes from being conflated with those applying "incident to" billing. The term "direction" was specifically selected to prevent "incident to" billing supervision requirements from being incorrectly or inaccurately applied to the Adaptive Behavior Service code set.

Unlike "incident to" services, QHP "supervision" (direction) of a technician's work is required only for a relatively small portion of the technician's overall service delivery time.[7] Unlike "incident to" services, CPT® 97153 and CPT® 97154 technician direct treatment services may be provided in a variety of settings, including home and community settings, where the BCBA®-QHP is neither present nor immediately available.

Unlike "incident to" services, the BCBA®-QHP may receive a higher rate than the technician for performing the service. In addition, unlike "incident to" services, when the BCBA®-QHP is present and directing the technician, both the work of the technician and the work of the BCBA®-QHP may be compensated (concurrent billing) since they are delivering separate and distinct services.

In sum, "incident to" billing requirements do not apply to ABA and Adaptive Behavior Services rendered through the Medicaid fee-for-service benefit or Managed Care entities. They also don't apply to benefits covered through a commercial payer.

It should be noted that even when "incident to" billing requirements are applicable, they do not explicitly require a co-signature by the authorized QHP.

Co-signature requirements may be part of valid and properly noticed contractual obligations

While "incident to" billing does not apply to behavior technician services—and a co-signature on technician session notes is not required by industry standards—a payor could, presumably, impose a co-signature requirement as a contractual obligation.

---

[7] Council of Autism Service Providers, Applied Behavior Analysis Practice Guidelines for the Treatment of Autism Spectrum Disorder (Third Edition) pp. 59-60, available at https://www.casproviders.org/asd-guidelines.

But in order for such a requirement to comply with state and federal laws, including the Wellstone-Domenici Mental Health Parity and Addiction Equity Act (MHPAEA), which would require that signature demands also be imposed on medical/surgical treatment to the same extent and no less stringently. In addition, the payor would need to provide adequate notice that this specific requirement applied to ABA services.

Policy arguments for imposition of a co-signature requirement are not strong

Fraud, waste, and abuse arguments

Assuming a payor can apply a co-signature requirement to behavior technician session notes consistent with applicable law, a further question is whether this is advisable and effective to achieve the ends sought. Some payors' policy and billing guidance suggest that co-signatures help prevent fraud, waste, and abuse (FWA).

CASP supports actions by payers to prevent FWA and ensure the provision of medically necessary services. However, requiring the BCBA®-QHP to co-sign every note does not ensure a thorough, detailed internal audit at the group or individual provider level. Instead, in practice, the co-signature often becomes an administrative act only and a burden that may do little to prevent FWA. Similarly, requiring a parent signature to confirm a service was rendered does little to prevent FWA or ensure accurate documentation of services when the service is provided in a center or community setting (away from the parent or legal guardian).

Case management and direction arguments

Review and counter-signing of all daily session notes is unlikely to materially improve case management and direction. Daily session notes are one source of information for a supervising BCBA®-QHP that may be highly relevant in specific instances. However, on balance, the data generated from sessions combined with direct observations and assessments—including those during CPT® code 97155 protocol evaluation and modification sessions—are likely to have the most relevance for a BCBA®-QHP's case management and direction.[8] Imposing blanket requirements that reduce time for indirect case management and analysis activities can be counterproductive to effective, efficient case management.

Questions?

Contact advocacy@casproviders.org or info@autismlegalresourcecenter.com.

---

[8] The BCBA® provides case management and direction through a variety of direct and indirect mechanisms, including designing the behavior treatment plan for the technician to carry out with the client, drafting the treatment plan session instructions to be followed by the technician, meeting with the technician to review the treatment plan and activities, designing protocols and a data collection system for the technician to record assessments and enter data, periodically observing the technician's provision of direct care, and reviewing the data taken during the technician's sessions.