

Q&A not answered live in recording:

Q: Does the client have to be PRESENT in order to bill for 97152?

A: Yes, the client needs to be present for the use of 97152.

Q: In reading through the description on pg. 3 "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 min" I think that "administered by" does a lot of work here because that explains that the technician will be completing this but also "under the direction of" does not specify that the QHP needs to be in the presence of the technician and the client.

A: You are correct that the supporting assessments are administered by the technician under the direction (which equates to the prep work that would go into the session with the QHP and technician and bundled) and the QHP does need to be on-site and interruptible during the face to face time as well.

Q: In the Q/A section the question about performing the assessment independently is answered by specifying that the technician is conducting an assessment that's been determined is needed by the QHP and that the QHP needs to review the assessment procedures with the technician. In reading all of this I believe that the intent of the statement is to ensure that behavior technicians do not evaluate what assessments need to be completed and independently administer them without the guidance of a QHP and the intent is not that.

A: Correct, the discussion and prep for necessary supporting assessments is covered by the QHP and the technician outside of the face to face session.

Q: So which other codes can 97152 be billed concurrently with?

A: There are no codes that would be billed concurrently with 97152 for the client receiving the supporting assessment.

Q: If we don't have a contract with a payer, do we have to follow their code implantation, whether or not it's in writing?

A: Payer policies for medical necessity and claims submission are relevant to in network and out of network providers.

Q: Are the MUE restrictions that are currently in place for Medicaid claims going to be applied to private insurance billing in the future, specifically the restriction on the 97154 group therapy code being limited to 3 hours per day? If so, do we know when the restrictions will take effect?

A: MUE limits apply to all payers using the Category I codes and were implemented 1/1/19. Independent notifications are not sent to providers, but available much like the CPT Manual is available and updated annual as well.

Q: For something like a potty training being provided solely by a BCBA (solo practitioner) how would you suggest requesting additional hours outside of the MUEs? I would be using the 97155.

A: MUE's aside, this is an authorization for medical necessity question and therefore, I would look to how your treatment program will be implemented with each of the code descriptors. If the treatment is by protocol from the initial assessment or re-assessment, the treatment protocol is billed as 97153, even if a BCBA sole provider. This is where you will need to work with the health plans to add a modifier and corresponding rate for this level of provider to do direct treatment. During the length of the treatment, you may also have instances where you need to analyze for treatment protocol modification, at which time you should be approved to use 97155, even without a technician present.

Q: In my reading of this code the QHP can provide direction to the technician and then they will be able to implement the assessment. Why does this need to be a in person with the QHP and behavior technician?

A: The "before" and "after" activities that are reflected in the supplemental guidance and the APBA recorded webinars with clinical examples show this prep work as non billable and bundled into the rate for the face to face activity.