

# Applied Behavior Analysis (ABA) Frequently Asked Questions

*May 2026*

<b>Training, Education &amp; Resources</b> .....	<b>2</b>
<b>Communication</b> .....	<b>2</b>
<b>Assessments</b> .....	<b>3</b>
<b>Parent/Caregiver Training</b> .....	<b>6</b>
<b>Supervision</b> .....	<b>7</b>
<b>Treatment Planning</b> .....	<b>8</b>
<b>Telehealth</b> .....	<b>9</b>
<b>Direct Treatment</b> .....	<b>10</b>
<b>Diagnosis</b> .....	<b>10</b>
<b>Addendums</b> .....	<b>12</b>
<b>Authorizations</b> .....	<b>13</b>
<b>Insurance</b> .....	<b>20</b>
<b>Backdating</b> .....	<b>21</b>
<b>Clinical Documentation</b> .....	<b>21</b>
<b>Parental Consent</b> .....	<b>25</b>
<b>Group Services</b> .....	<b>26</b>
<b>Discharge</b> .....	<b>27</b>
<b>Audits</b> .....	<b>29</b>
<b>Critical Incident / Sentinel Event Reporting</b> .....	<b>35</b>
<b>Claims &amp; Billing</b> .....	<b>36</b>
<b>Credentials &amp; Licensing</b> .....	<b>37</b>
<b>Continuity of Care</b> .....	<b>38</b>
<b>Referrals</b> .....	<b>39</b>
<b>School-Based Services</b> .....	<b>39</b>

## Training, Education & Resources

### **Where can I access the slides?**

Slides for all our trainings are available on our website under [Provider Training & Education](#).

### **Could we have a link to the Maryland Department of Health regarding ABA, or is everything listed in the COMAR/Provider Handbook?**

The Maryland Department of Health's ABA website can be found at <https://health.maryland.gov/mmcp/epsdt/ABA/pages/home.aspx>.

### **Will there be training on *ProviderConnect* for authorization submissions?**

Yes, please check out our monthly calendar on the website's [training library](#) for upcoming training.

## Communication

### **How will providers be informed about changes to telehealth?**

Providers should sign up for provider communications to receive alerts about any changes or updates. You can register at [Sign Up for Provider Communications](#). Additionally, updates can be found on our [Communications page](#). It is also advisable to regularly check the [MDH website](#) for any updates.

- Please review the most recent ABA provider alert and transmittal here related to updated telehealth requirements: [Updated ABA Telehealth Requirements](#).

### **How do we sign up for provider alerts?**

You can sign up for Carelon provider communication on our website: [Carelon Provider Communications](#)

- Reference: <https://maryland.carelonbh.com/aba-providers>

## Assessments

### **Can an RBT conduct the direct observation component for CPT code 97152?**

An RBT can assist with the evaluation of the participant's current level of functioning, skills deficits, and maladaptive behaviors using validated instruments. However, a BCBA must be involved in the assessment process. Observations and administration of validated instruments must be completed in person. The behavior identification supporting assessment should be conducted by one technician under the direction of a physician or other qualified healthcare professional. The observation that the RBT/BT/BCaBA may conduct does not replace the one the BCBA is required to conduct.

### **Is it permissible for a BCBA to conduct 97151 services with the client either after 97153 services have concluded or before they begin?**

Yes, BCBAs are permitted to conduct 97151 services either after 97153 services have concluded or before they begin. Additionally, 97151 can occur simultaneously with 97153, provided there are distinct qualified health professionals rendering both services, and that both services meet the authorized service criteria for each code.

CPT code 97151 involves face-to-face interactions with the patient and/or guardian/caregiver for administering assessments and discussing findings and recommendations. It also includes non-face-to-face activities such as analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan. On the other hand, 97153 is a face-to-face service with the patient focusing on the direct 1:1 implementation of the behavior intervention plan and instruction of acquisition goals outlined in the treatment plan. This may include probing of skills not yet targeted in the treatment plan.

- Reference: [Maryland Medicaid ABA Service Codes Description](#)

### **Does 97151 for reauthorization need to be completed in person?**

Yes, 97151 must be completed in person and does not allow for telehealth.

- Reference: [Maryland Medicaid ABA Service Codes Descriptions](#)

### **Can 97151 be used to develop the discharge report within 30 days of discharge?**

97151 can be used if assessing the client's skills/behaviors.

- Reference: [Maryland Medicaid ABA Service Codes Descriptions](#)

### **Can we bill 97151 for a Functional Analysis Interview (FAI) with the family conducted via phone or Telehealth in preparation for the initial observation?**

ABA providers may not bill the program for services rendered by mail or telephone. In addition, 97151 must be completed in person. Assessments with the client or caregivers must be conducted face-to-face.

Reference(s):

- [Maryland Medicaid ABA Service Codes Descriptions](#)
- Limitations: [ABA Provider Manual](#)

### **If it's an Initial Assessment (IA), and the client is going into the clinic, how would we observe the client in the clinic if they're not there yet?**

Medical necessity must be met in order to deliver services in the clinic setting. Observations need to be completed where services will be conducted. Best practice involves observing the individual across different relevant settings to provide a comprehensive view of their behaviors, skills, and needs in various contexts.

- Reference: [Maryland-Medicaid-ABA-Treatment-Plan-Requirements](#)

### **Do observations for concurrent observations have to be in person, or can they be conducted via telehealth?**

Yes, observations must be completed in person. Code 97151 does not permit services to be conducted via telehealth.

- Reference: [Maryland Medicaid ABA Service Codes Descriptions](#)

### **For an initial assessment, are two observations always required?**

Observations need to occur in the setting(s) where services will be rendered. Best practice guidelines recommend collecting sufficient data samples to provide a clear understanding of behaviors, ensuring that appropriate clinical decisions can be made. Ideally, behaviors should be observed across different times, days, and settings for a comprehensive assessment.

Observations can potentially be billed under 97155 if they involve assessing the client's current level of behaviors and the effectiveness of interventions to make necessary adjustments to the treatment plan. However, it is essential for providers to ensure that all activities comply with the specific billing criteria and guidelines associated with 97155.

Per Maryland Dept. of Health's treatment plan requirements, the direct observation narrative is to be a narrative of the **in-person** observation of when the assessment was conducted. Should providers decide to report based on their supervision observation, it is to be a narrative of their **in-person** supervision observation, not telehealth session.

Reference(s):

- [Maryland Medicaid Treatment Plan Template with Instructions](#)
- [Maryland Medicaid ABA Service Codes Descriptions](#)

### **Where is it outlined that two observations for an assessment are required?**

Observations need to occur in the setting(s) where services will be rendered. Best practice guidelines recommend collecting sufficient data samples to provide a clear understanding of behaviors, ensuring that appropriate clinical decisions can be made. Ideally, behaviors should be observed across different times, days, and settings for a comprehensive assessment.

Reference(s):

- Page 3: [Maryland Medicaid Treatment Plan Template with Instructions](#)
- Page 20: [CASP ABA Practice Guidelines](#)
- [Maryland Medicaid ABA Treatment Plan Requirements](#)

### **Is it permissible to conduct two observations on the same day?**

Yes, observations can be conducted on the same day, provided they occur in the setting(s) where services will be delivered. Best practice guidelines suggest collecting sufficient data samples to gain a clear understanding of behaviors, which aids in making informed clinical decisions. Ideally, behaviors should be observed across different times, days, and settings to ensure a comprehensive assessment.

Reference(s):

- Page 3: [Maryland Medicaid Treatment Plan Template with Instructions](#)
- Page 20: [CASP ABA Practice Guidelines](#)

### **Are two observations required for both initial assessments and reassessments, and if so, can these observations be billed under the 97155 code?**

Observations need to occur in the setting(s) where services will be rendered. Best practice guidelines recommend collecting sufficient data samples to provide a clear understanding of behaviors, ensuring that appropriate clinical decisions can be made. Ideally, behaviors should be observed across different times, days, and settings for a comprehensive assessment.

Observations can potentially be billed under 97155 if they involve assessing the client's current level of behaviors and the effectiveness of interventions to make necessary adjustments to the treatment plan. However, it is essential for providers to ensure that all activities comply with the specific billing criteria and guidelines associated with 97155.

Reference(s):

- [Maryland Medicaid Treatment Plan Template with Instructions](#)
- [Maryland Medicaid ABA Service Codes Descriptions](#)

## Parent/Caregiver Training

**How should we document attempts to schedule and complete parent trainings when families cancel or do not respond?**

Organizations should document attempts to schedule parent training, cancellations, and reasons for cancellations in the client's medical record. This documentation should also include rescheduling efforts and any attempts made by the provider to address barriers preventing attendance. These details should be included in the progress report.

**What are examples of effective parent training goals?**

Examples of effective parent training goals include:

- **Understanding ABA Principles:** Parents will demonstrate an understanding of basic ABA principles by correctly defining and identifying three examples in 90% of opportunities across three consecutive days.
- **Establishing Consistent Routines:** Parents will establish and maintain consistent morning and evening routines, achieving 90% adherence to the planned activities over five consecutive days.
- **Implementing Behavior Intervention Plans:** Parents will implement the Behavior Intervention Plan (BIP) to reduce aggression with 90% accuracy across two consecutive weeks.
- **Increasing Communication Attempts:** Parents will increase communication attempts by prompting requests using the AAC device in 90% of opportunities across two consecutive weeks.

**Can BCBA's conduct parent training with the client after 97153 services have concluded or before they begin?**

Yes, BCBA's can conduct parent training (CPT code 97156) either after 97153 services have concluded or before they begin. It is important to note that 97156 with modifier U2 cannot overlap with 97153, meaning these two services cannot be billed concurrently. However, 97156 without modifier U2 can be billed concurrently with 97153. Parent training is intended to take place with the parent or guardian and can occur with or without the client present.

- Reference: [Maryland Medicaid ABA Service Codes Description](#)

## **Can 97156 be used to coordinate care with school providers and similar institutions?**

97156 is designated for equipping parents/caregivers with the skills necessary to maintain the client's progress outside of sessions and alleviating the core challenges associated with an ASD diagnosis, which as of 2/1/26 includes coordinating care with other providers.

- Reference: [Maryland Medicaid ABA Service Codes Descriptions](#)

## **Can we use the Parent Training (97156) model and not 97153?**

Yes, the parent training model can be utilized when it is clinically indicated. This approach can be a productive way to systematically transition or phase out of services efficiently.

## **What is meant by “the level of parent education is appropriate”?**

COMAR 10.09.25.05 guideline related to caregiver/parent training outlines the following: “D. The participant’s parent or caregiver shall be trained to reinforce ABA services for the participant in a clinically effective manner”. The overall goal of ABA therapy should focus on providing the skills necessary to both the member and the family to be independent of support staff when future needs arise. Training of family is done to promote generalization and maintenance in the most natural settings.

## Supervision

### **Are we allowed to exceed the 20% supervision limit in a month if we have approved hours and it is necessary to implement the current program? How should we document and communicate this need to the Maryland Department of Health (MDH) and Carelon to ensure compliance and transparency?**

Supervision is established at 10-20% of direct units rendered, following the standard practice guideline of "2 hours for every 10 hours of direct treatment." When medically necessary and clinically appropriate, ABA providers may exceed the 20% supervision recommendation. A participant-specific clinical rationale must be documented in the treatment plan when this occurs

Reference(s):

- Page 10: [Model-Coverage-Policy](#)
- Page 10: [Maryland-Medicaid-Treatment-Plan-Template-with-instructions](#)

**Can two BCBA's share supervision (97155) for the case? One in person and one via telehealth?**

Yes, as long as both BCBA's are approved, Medicaid Providers registered to deliver services under the authorized organization.

**Are we able to make up missed 97155 hours across the authorization period if we don't meet the 10% in a given month?**

While you can make up missed hours during the authorization period, you must still fulfill the 10% supervision requirement each month.

## Treatment Planning

**Since H2012 is no longer going to be used, will the approved units for 97151 be increased?**

For initial assessments, 97151 may be approved for up to 32 units per authorization period. For reauthorization, up to 12 units may be approved.

**Now that H2012 is no longer an approved code, is there a billable code for progress monitoring and treatment plan updates?**

97151 may be used to:

- Conduct assessments and discuss findings and recommendations with the participant and/or their guardian/caregiver present.
- Analyze data, score assessments, and complete the treatment plan without the member or guardian/caregiver present.

97155 may be used:

- When the participant and technician are present.
- To analyze data and conduct observations to determine if protocols (e.g. targets, goals, prompts, etc.) require modifications, implement or probe protocols to assess if changes are needed, and make necessary protocol modifications.

**When making program modifications, should these changes be attached to session notes for 97155?**

Session notes for 97155 should clearly indicate the service provided, detailing any data reviewed, progress made/not made with objective data, program modifications and their rationale.

- Reference: [ABA Provider Manual](#)

**Can H2012 be billed for Telehealth services, and does the client need to be present for billing under this code?**

As of 2/1/25, H2012 is no longer a covered service under the Maryland Medicaid ABA benefit.

- Reference: [12.19.25 Provider Alert](#)

**Telehealth**

**Are there exceptions to the requirement that 25% of 97155,97156, and 97157 be conducted in person?**

Exceptions will be reviewed on a case-by-case basis by the Maryland Department of Health (MDH).

**What codes are allowed to be rendered via telehealth?**

Codes 97155, 97156, and 97157 can be conducted using a two-way audio-visual telehealth delivery model, provided they have been authorized. Additionally, client consent for telehealth services must be obtained, and the telehealth readiness checklist must be completed. As of April 1, 2026, CPT Codes 97155, 97156, and 97157 must be completed in person at least 25% of the time each month.

Reference(s):

- Pages 9, 10, 14, 15: [ABA Provider Manual](#)
- [Maryland Medicaid ABA Service Codes Description](#)
- [COMAR 10.09.28.04 B \(6\) \(7\) \(10\)](#)
- [Maryland Medicaid ABA Treatment Plan Template Instructions](#)

**Can CPT Codes 97155, 97156, and 97157 be conducted 100% via telehealth?**

As of April 1, 2026, CPT Codes 97155, 97156, and 97157 must be completed in person at least 25% of the time each month.

- Reference: [COMAR 10.09.28.04 B \(6\) \(7\) \(10\)](#)

**What grace period will we be given for reverting to 25% in-person and 75% telehealth?**

As of April 1, 2026, CPT Codes 97155, 97156, and 97157 must be completed in person at least 25% of the time each month.

- Reference: [PT 60-26 Updates to ABA Telehealth](#)

## Direct Treatment

### **Can the same RBT conduct two sessions in one day using code 97153?**

Yes, an RBT can conduct two sessions in one day using code 97153, for a total of up to 32 units (equivalent to 8 hours) per day. Up to three different providers can deliver services under code 97153, but the combined total for all providers should not exceed 32 units (8 hours) in a single day.

- Reference: [Maryland Medicaid ABA Service Codes Description](#)

### **Is a caregiver required to be present in the house, or can the RBT be there without one?**

It is up to your agency how to best follow state policy and best practices. When documenting the parent/guardian presence/absence, please ensure "a description of the participant's parent or caregiver's participation in the ABA treatment sessions, including the parent or the caregiver's name and relationship to the participant, date, and time of participation or notification of the participant's parent or caregiver's consent to be absent;"

- Reference: [Pages - 10.09.28.04](#)

## Diagnosis

### **Will there be a list of upcoming Comprehensive Diagnostic Evaluation (CDE) expirations sent out?**

Comprehensive Diagnostic Evaluations (CDE) do not expire. A [Clinical Confirmation Form \(CCF\)](#) is only required if the participant was diagnosed with Autism Spectrum Disorder (ASD) by a QHCP at 3 years and 1 month or younger AND it has been more than 2 years since that initial diagnosis. **It is the ABA provider's responsibility to track when the CCF is/will be due.** Our Care Managers will provide a courtesy reminder when sharing clinical feedback due at the next request, using the clinical contact provided on the ABA authorization request form.

Reference: Page 7- [ABA Provider Manual](#)

### **I've noticed that some families have a terrible time trying to locate the original CDE. What can we do if they cannot locate it?**

The original CDE is required for authorization and compliance with Medicaid requirements. We encourage providers to support families by assisting them in contacting the diagnosing provider to obtain a copy of the report.

## **How long is the CDE valid?**

There is no expiration date for a CDE; it remains valid indefinitely. However, if a member was diagnosed before the age of 3 years and 1 month, a clinical confirmation form is required after 2 years.

- Reference: [Clinical Confirmation Form](#)

## **Do diagnostic evaluations indicating an ASD (F84.0) diagnosis need to be signed with an ink signature, or is an electronic signature acceptable?**

An electronic signature is acceptable.

## **Is a diagnostic report from a non-QHCP (i.e., school psychologist or speech-language pathologist) within the last three years accompanied by the Carelon Maryland form: Physician Confirmation of Autism Spectrum accepted?**

No. The Complete Diagnostic Evaluation, ABA Referral Form and/or Clinical Confirmation Form must be completed by a Qualified Health Care Professional, which includes a Pediatrician or Developmental Pediatrician; Pediatric Neurologist; Child Psychiatrist; Clinical Psychologist; Nurse Practitioner; Neuropsychologist.

## **Are primary care providers allowed to diagnose patients with autism?**

The Complete Diagnostic Evaluation, ABA Referral Form and/or Clinical Confirmation Form may be completed by a Qualified Health Care Professional, which includes a Pediatrician or Developmental Pediatrician; Pediatric Neurologist; Child Psychiatrist; Clinical Psychologist; Nurse Practitioner; Neuropsychologist.

## **I continue to see that if a learner was diagnosed before age 3, they need a re-diagnosis. I have a learner diagnosed at 3 years and 10 days, which was denied stating the learner needs to be re-diagnosed. Which is it, 3 years or 3 years and 1 month?**

If a learner was diagnosed with ASD before the age of 3 years and 1 month, and it has been more than two years since that diagnosis, an updated Clinical Confirmation Form (CCF) is required for obtaining initial assessment authorization. In your case, where the learner was diagnosed at 3 years and 10 days old and received a denial, a Clinical Confirmation Form may have been needed if it has been more than 2 years of the initial diagnosis. For initial assessment requests, the ABA referral or recommendation must be recent, specifically within six months of the request.

- If there is any uncertainty or a need to avoid adverse determinations, you may request a "pre-review/mini review" of your documentation. To do this, you can email [MDH.ABACareCoordinatorsFAX@carelon.com](mailto:MDH.ABACareCoordinatorsFAX@carelon.com), specifying your request for a pre-review, and attach the related documents.

- This pre-review does not constitute an official request. After receiving feedback from the pre-review, you will need to submit an official request through *ProviderConnect*. This process can help ensure that all documentation is current and meets the necessary criteria.

## Addendums

**For addendums, are you still requiring the previous treatment plan to be attached? Does the entire report need to be completed or just enough information to justify the increase or change?**

When submitting an addendum request, you may include the previous treatment plan. The key requirement is a document indicating that an addendum to an existing authorization is being requested, along with the reason and clinical documentation supporting the request.

Clinical documentation should include:

- An updated treatment plan with a clinical rationale, supporting data and details of any changes to the treatment. Ensure the treatment plan, member information and data are as current as possible to reflect member's real-time needs.
- An updated ABA Authorization Request Form with the noted changes.

**NOTE:** in some cases, an addendum will suffice while in others a fully updated report might be necessary to support the request.

When you are ready to submit for review, you can send your documentation via email to [MDH.ABACareCoordinatorsFax@Carelon.com](mailto:MDH.ABACareCoordinatorsFax@Carelon.com) or by fax at [1-888-586-1345](tel:1-888-586-1345).

- Reference: [7.8.25-Initial-Concurrent-ABA-Authorization-Request-Requirements](#)

**If there is a POS change during the current authorization, for example if a child is getting services in home but wants to come to the clinic 1 day per week for social groups, do we need to submit an addendum or do we just report on that change, progress, and reason at the reauthorization?**

The Maryland Department of Health has established Clinic and School Medical Necessity Criteria. Therefore, if there is a POS change during the current treatment authorization, please submit an addendum request that includes the clinical rationale for the change.

- Reference: [ABA Provider Manual](#)

**We were informed that there are no longer addendum forms during an open authorization and instead we must revise the entire treatment plan. If we are just submitting to increase one specific code (i.e. parent training), do we have to update all skill acquisition objectives or just the ones related to the request? If we must revise the entire plan, are we able to request an additional three hours of 97151 for the 6-month reassessment since revising the plan for the addendum will use them?**

Below is the guide when in need of submitting an addendum request:

- A document signaling that an addendum to an existing authorization is being requested, with the reason and clinical documentation supporting the request. Clinical documentation includes:
- An updated treatment plan that includes a clinical rationale with supporting data and any/all changes to the treatment due to the increase. The treatment plan, member information and data must be as current and up to date as possible to allow for the member's need for increased care in real time.
- An updated [ABA Authorization Request Form](#) with the noted changes requested
- Please note in some cases an addendum will suffice while in others a fully-up-to-date report might be necessary to support the request.
- When you are ready to submit for review, you may submit via Carelon's provider portal, [ProviderConnect](#).

## Authorizations

### **What is required to justify center settings?**

Services in the clinic-based setting may be appropriate due to the following:

- A functional analysis in which scenarios will be tested include a high probability for explosive, aggressive or self-injurious behavior.
- ABA treatment is provided to participants with severe behavior such that it may be unsafe for them to be treated in the home setting and may necessitate multiple staff to be present.
- ABA treatment provided to participants whose home environments are considered not safe, as a current health hazard or environmental barrier is present that the provider demonstrates an inability to mitigate.
- ABA treatment provided in a group and/or targeting social skills with two to eight other participants.
- Multi-family group training with caregivers without children present

## **What is the Medical necessity criteria needed when requesting an increase in hours?**

The complete Medical Necessity criteria are available on [Carelon's website](#). To request an increase in hours, deficits and excess behaviors necessitating a more intensive level of care must be demonstrated. Providers should be utilizing the current authorized hours before requesting an increase.

- Reference: [ABA Provider Manual](#)

## **We just got feedback that telehealth supervision for center care is a concern. Is this something that will be denied or can we get clarification of what the requirements are for telehealth?**

For questions regarding authorizations and telehealth supervision requirements, please contact [MDH.ABACareCoordinatorsFax@Carelon.com](mailto:MDH.ABACareCoordinatorsFax@Carelon.com) for clarification and further assistance.

## **Can you provide clarification on how to obtain an appeal response faster?**

For questions regarding appeals, please contact [1-844-231-7949](tel:1-844-231-7949).

## **We have recently received feedback that data must be within 30 days for concurrent treatment plans. Previously we were told 60 days from the date of auth expiration. Can you provide further details regarding this policy and where it is located in the Carelon documents?**

When submitting initial treatment, concurrent treatment and/or addendum requests, *progress data within 30 days of the request is required*. This ensures that the assessment accurately reflects the participant's most current clinical presentation. For example, if a concurrent treatment plan is submitted 8/1/2025, the assessment and progress data should be no older than 7/2/2025.

## **Does the observation need to be within 30 days as well?**

Yes, when submitting initial treatment, concurrent treatment, or addendum requests, the observation *must be within 30 days of the request* to ensure an accurate assessment of the participant's current clinical presentation. For instance, if a concurrent treatment plan is submitted on 8/1/2025, the observation should have occurred no earlier than 7/2/2025.

## **Is a Clinical Confirmation Form required for each reauthorization?**

No, a Clinical Confirmation Form (CCF) is not required for each reauthorization. It is required only if the participant was diagnosed before the age of 3 years and 1 month, and it has been more than two years since the initial diagnosis. Additionally, a copy of the Qualified Healthcare Provider (QHCP) visit summary, dated within the last six months from when the CCF is completed, is also necessary.

For example, if a participant was diagnosed at 2 years old on 1/1/2024, an updated CCF would be due on 1/1/2026.

References:

- Page 7: [ABA Provider Manual](#)
- [Initial & Concurrent ABA Authorization Request Requirement July 8, 2025](#)
- [Maryland Department of Health Provider Training](#)

## **Will we receive an alert when a CCF is required?**

Providers are responsible for knowing when a CCF is needed for a client. Our staff will send reminders when documentation indicates that a client might need an updated CCF as we issue authorizations.

**Can an internal provider collaboration form, which logs communication with external providers, be submitted alongside treatment plans during re-authorization, or should collaboration details be documented directly within the treatment plan?**

Coordination of care details need to be documented directly within the treatment plan.

- Reference: [Maryland Medicaid Treatment Plan Template with Instructions](#)

## **What criteria are referenced when determining the medical necessity and approval or denial of the use of 97154 in authorizations for children?**

A participant-specific clinical rationale must be included in the report, confirming readiness for learning in a group setting without direct, one-on-one RBT support. This code entails that multiple children can be managed by one Qualified Health Professional (QHP). The ABA provider must submit updated progress demonstrating that the participant can successfully engage in a non-1-1 setting, with goals targeted in this context. It's essential that both the participant and other children in the group remain safe, indicated by lower rates or mastery of targeted excess behaviors.

According to the ABA Coding Coalition's [Model Coverage Policy](#) for Adaptive Behavior Services: "Treatment may begin with 1-1 sessions, gradually transitioning to small-group formats as appropriate. Initially, structured sessions are common, but more naturalistic methods can be introduced as suitable. As patients progress and meet criteria, treatments may occur across multiple settings."

**What is the process for handling requests for additional information that delay approval? How many days do we have to respond to such requests or report edits?**

When the Carelon Maryland team contacts providers to request missing information or documentation, a deadline will be included in the email. To prevent adverse determinations or processing delays, please ensure that all required documents are submitted according to the type of service for which you're seeking approval.

- Reference: [7.8.25-Initial-Concurrent-ABA-Authorization-Request-Requirements](#)

**What is the process when services are partially or fully denied?**

A participant, provider, or participant advocate (with the participant's consent) may request a reconsideration following a clinical non-coverage determination that was made without a peer-to-peer review. This request must be submitted within three calendar days from the initial determination.

- Reference: Page 14: [Carelon Maryland Provider Manual](#)

**When submitting a concurrent request, it didn't allow me to put units for certain codes - how do I get around that?**

Please ensure that the treatment plan and ABA Authorization Request Form submitted have all the CPT codes, total units requested, and place of service accurately reflected. Our Care Managers look at both forms to determine the provider's request versus what is entered in Carelon's system.

**Do re-authorizations require an in-person direct assessment, or can they be completed virtually? Also, does it need to occur in the POS, or could the parent bring the client into the clinic to complete the assessment even if services are being provided at home?**

When conducting Initial Assessments or Reassessment, a direct/in person observation(s) in the setting where services will be/are rendered is best practice and required. For further information related to the required information when submitting treatment plans, please review the Treatment Plan Requirements Guide and associated Instructions.

- Reference: [Maryland Medicaid ABA Treatment Plan Requirements](#)

### **Why is it taking so long to process our authorizations?**

All requests have the same turnaround time of 7 calendar days. When the requests are submitted via email or fax, they will be entered with the "received date" and the time will start on that date. In *ProviderConnect*, you will not be able to see the request as pending. Should you want to obtain an authorization status request, you may contact us via [MDH.ABACareCoordinatorsFAX@carelon.com](mailto:MDH.ABACareCoordinatorsFAX@carelon.com) and we may provide a timeline on your request.

### **Can you add the Carelon authorization form to the ABA Provider Manual? It is not indicated anywhere that that form needs to be completed except in Provider Alerts.**

Yes. The ABA Provider Manual is shared by the Maryland Department of Health (MDH) and will be updated by MDH. As the ASO, we are requiring the [ABA Authorization Request Form](#) to ensure that we have the correct provider information to share authorization details and feedback after a determination is made, to obtain the start date of the authorization, and to cross-reference the units and codes requested to what is outlined in the treatment plan.

### **Are we able to request 52 for reassessments (meaning we would need more than three hours for reassessment so the Board-Certified Behavior Analyst (BCBA) can partake)?**

ABA providers are able to obtain CPT 97152 units when clinically justified. This code is complementary to 97151. MDH and CBH does not pay for training staff. It is the responsibility of the provider group to train their staff.

CPT 97152 is meant for BCaBA/RBT/BT to assist with the evaluation of the participant's current level of functioning, skills, deficits, and maladaptive behaviors using validated instruments. The observations and administration of validated instruments completed by the BCBA must be completed in person as the CPT code is not eligible to be done via telehealth. In addition, the observations completed in person by the technician would not replace those to be completed by the BCBA under 97151.

While in some specific cases, when clinically evidenced, higher reassessment may be approved, these are rare and must be evidenced with client specific needs and data.

- References: [Maryland Medicaid ABA Service Codes Descriptions](#)

**Do we need to obtain an ABA referral every six months for concurrent authorization requests?**

No, an updated referral/recommendation is required when submitting a request for initial assessments only. If the participant was diagnosed under 3 years 1 month of age and it has been more than two years since that initial diagnosis, then an updated Clinical Confirmation Form (CCF) is required to obtain initial assessment authorization or concurrent treatment authorizations. Within the form, an ABA referral/recommendation is noted for the QHCP.

**Can you please clarify if we need to have an assessment approval from Carelon prior to submitting our Initial Treatment request?**

Yes. In certain circumstances, for continuity of care purposes, we may be able to skip the initial assessment request. For example, if the participant obtained the initial assessment under a different funder and now the initial treatment request is being submitted to Carelon / Maryland Medicaid. Please note that at the time of the request, Carelon will need to conduct a pre-authorization criteria review. The Comprehensive Diagnostic Evaluation (CDE) / ABA Referral Form and/or Clinical Confirmation Form must be submitted along with your initial treatment request.

**Is additional 97151 granted upon request (with medical necessity rationale) should additional assessment exceed the provided units?**

Yes, during reassessment, additional units can be authorized if the standard 12 units (3 hours) are utilized before the end of the authorization due to clinical need. While in some specific cases, when clinically evidenced, higher reassessment may be approved, these are rare and must be evidenced with client specific needs and data.

**Can you no longer request a provider change without doing the assessment?**

Participants can obtain authorization from an initial assessment while still receiving services from their current provider. The Continuity of Care Form will be required along with a parent/guardian note, in order for the initial assessment to be authorized.

**If a client has a gap in services due to illness or being out of the country, is there a time frame where a new assessment is required?**

It depends on how extensive the gap is, and it is up to the provider how they may want to proceed. When submitting an initial, concurrent treatment and/or addendum request, the data and information on the report must be within 30 days of the submission. If the hold has been substantial, for example, more than four months, it is likely clinically indicated to conduct a new initial assessment to ensure the plan is tailored to the members current needs.

## **Will you be sending authorization approval emails or do providers need to check *ProviderConnect*?**

When a provider submits the ABA Authorization Request Form along with their request, our Care Managers email the provider feedback and authorization details. Providers will also be able to obtain the authorization details on *ProviderConnect* and be able to print the authorization details.

## **I have noticed that we have not received units for reassessment 97151 in our requests. But units have been added to H2012 to be 128 instead of the typical 112. Is that where the units are? If not, how do I get 97151 for these participants?**

Carelon creates and approves authorizations by authorization class. CPT H2012 is no longer a covered code as of 2/1/2026. Below is the new list of ABA authorization classes and their corresponding CPT codes:

- ABO: 97151, 97152, H2012
- ABT: 97153, 97154
- ABR: 97155 and 97155 GT
- ABH: 97156, 97156GT, 97156U2, 97156U2/GT, 97157 and 97157GT
- ABG: 97158
- ABS: 0362T
- ABE: 0373T

An example of how to interpret these classes and codes is as follows:

CPT codes 97156 and 97157 GT belong to Authorization Class ABH. When a provider submits a request for 97156: 104 units and 97157 GT: 24 units, the authorization in *ProviderConnect* will show as ABH: 128 units.

References:

- [H2012 Discontinuation Reminder & Updated ABA Resources](#)
- [ABA Authorization Classes and Recent Claim Denials](#)

## **When requesting 97155 and 97156, do we need to separate the number of hours we're requesting with the GT modifier?**

No, please request the total number of units of 97155 / 97155 GT or 97156 / 97156 GT / U2. Please ensure that the place of service is noted in the treatment and submit the [Telehealth Readiness Checklist](#) to obtain authorization of modifier GT.

Effective April 1, 2026, all ABA providers must include the required telehealth information released in the updated [Maryland Medicaid Treatment Plan Template](#) & Telehealth Readiness Checklist. The updated materials include graphs, an updated utilization report, and a revised telehealth readiness checklist. For more information, revisit the Provider Alerts: [Updated ABA Telehealth Requirements](#) and [H2012 Discontinuation Reminder & Updated ABA Materials](#)

## Do we have to include a GT modifier on the telehealth request form?

If you are requesting the telehealth modifiers for codes 97155, 97156 and/or 97157, please ensure to complete an updated Telehealth Readiness Checklist and ensure that this is requested in the treatment plan under Place of Service. If this is not received at the time of the review, we will not be able to authorize the modifier.

- Page 9: [ABA Provider Manual](#)
- Page 13: [Maryland Medicaid Treatment Plan Template with instructions](#)

## I have submitted authorizations previously without the telehealth checklist. I was told there would be flexibility with authorizing 97155 telehealth. Should I go back and resubmit these authorizations with the checklist?

Please send us an email via [MDH.ABACareCoordinatorsFAX@carelon.com](mailto:MDH.ABACareCoordinatorsFAX@carelon.com) so we may review the authorizations and inform you if the telehealth readiness checklist is required.

## Is previous reporting of utilization required?

Yes. Please review page 34 of [Maryland Department of Health Provider Training 2024](#).

## Insurance

### What is the process for utilizing codes like 97157 when Medicaid is the secondary payer? Specifically, do we need to submit an authorization request, and what are the billing requirements if the primary insurance does not cover these codes?

If the primary insurance does not cover a specific code (e.g., 97157) and you intend to bill Medicaid, an authorization is required for Medicaid to act as the primary insurer for that code. In such cases, you must obtain a denial from the primary insurance, which should be documented in the participant's file for the first few claims to demonstrate that the services are not covered by the primary insurance. When Medicaid is secondary, an authorization may not be required, but pre-authorization criteria must be met, including:

- **Complete Diagnostic Evaluation (CDE):** Conducted by a qualified professional, with a report including ASD diagnosis assessment results, current functioning, developmental history, and the diagnostician's signature.
- **Referral or Prescription:** Required and must be dated within six months of the initial assessment.
  - Clinical Confirmation Form (CCF): Necessary for participants diagnosed before age 3 years and 1 month, with more than two years since the initial diagnosis, accompanied by a QHCP visit summary from the last six months.

**If Medicaid is the secondary insurance, is the Clinical Confirmation Form still needed?**

Yes, the Clinical Confirmation Form is required even when Medicaid is the secondary insurance. All Medicaid standards must be met for Medicaid to cover services, regardless of its position as secondary payor.

Reference(s):

- Page 7: [ABA Provider Manual](#)
- Page 21: [Maryland Department of Health Provider Training 2025](#)

**Are authorizations still no longer required when Medicaid is secondary?**

If Maryland Medicaid is the participant's secondary insurance, an authorization is not required. When submitting claims, please ensure to also submit the EOB from the primary insurance as proof of payment from the participant's primary insurance.

**Backdating**

**Does Carelon allow retro authorizations? If so, for what reasons and how far back?**

Carelon allows backdating of ABA authorizations up to 20 calendar days.

- Reference: [Authorization Parameters](#)

**Clinical Documentation**

**If a client receives services in the clinic during the day and at home during the evening, would POS 99 be used even if different providers completed each session or only if it was provided by the same rendering provider?**

POS 99 would be utilized if the same provider is rendering services the same day in different locations.

- References: Page 56: [Maryland Department of Health Provider Training](#)

**Are there specific requirements for using pen and paper for session notes and data, such as ink color or marking errors?**

Documentation must be clear and legible to ensure others can understand and read the client's medical records.

**When completing a session note, is geolocation required or can it be a simple location such as a clinic, home, school, etc.?**

Geolocation is not required. A valid mailing U.S. address where services were rendered is required.

**What is the expectation for the timestamp of the provider signature on the session note? Is there a window of time in which the note has to be signed?**

Session notes should be signed at the time services are rendered or within 48 hours of the service. The time and date of the signature should be indicated.

**How do you timestamp handwritten notes?**

Handwritten notes should include the date and time when the notes were signed.

**Is there an example of appropriate and acceptable documentation for each billing code to ensure we are within compliance?**

Per COMAR 10.09.28.04 (F) required documentation must include:

1. The location, date, start time, and end time of the service;
2. A brief description of the service provided, including reference to the treatment plan;
3. A description of the participant's behaviors or symptoms in measurable terms;
4. A description of the participant's parent or caregiver's participation in the ABA treatment sessions, including the parent or the caregiver's name and relationship to the participant, date, and time of participation or notification of the participant's parent or caregiver's consent to be absent; and
5. A legible signature, along with the printed or typed name of the individual providing care, with the appropriate title.

Reference: [COMAR](#)

**What is the difference between the ABA Treatment Plan and ABA assessment which are required for initial assessment?**

Assessments are validated instruments to evaluate the member's skills or the function of their behavior. The treatment plan includes a summary of the assessment results, biopsychosocial information, goals, generalization strategies, transition and discharge plans, and treatment recommendations.

- Please review: [Maryland Medicaid ABA Treatment Plan Requirements](#)

**What information needs to be included in the reassessment report regarding data, and how granular does this data need to be?**

Integrating graphics for all goals is required as of 4/1/2026. Data should clearly reflect the data collection method and the mastery criteria for each goal.

References:

- [Maryland Medicaid Treatment Plan Template with Instructions](#)
- [Maryland Medicaid ABA Treatment Plan Requirements](#)
- [Provider Bulletin 3.27.26](#)

**Is it allowable to add information (such as insurance ID, service address, diagnosis, etc.) within the Client Information section on the Treatment Plan Template? Some of the information is not within the template provided and needs to be added in.**

Yes, as long as the treatment plan requirements are met providers can add additional information.

- Reference: [Maryland-Medicaid-ABA-Treatment-Plan-Requirements](#)

**Are caregiver/parent signatures required on the treatment plan?**

Consent to treatment is required. According to best practice guidelines and the BACB ethics code for behavior analysts (Code 2.11), behavior analysts are responsible for knowing about and complying with all conditions under which they are required to obtain informed consent from clients, stakeholders, and research participants (e.g., before initial implementation of assessments or behavior-change interventions, when making substantial changes to interventions, when exchanging or releasing confidential information or records). They are responsible for explaining, obtaining, reobtaining, and documenting required informed consent. They are responsible for obtaining assent from clients when applicable. Collecting caregiver/parent or participant signatures is an effective way to ensure that all parties understand and agree to the treatment plan.

References:

- [COMAR 10.09.28.04 A \(4\)](#)
- Page 8: [ABA Provider Manual](#)
- [Ethics Code for Behavior Analysts: 2.11](#)
- [Clinical Informed Consent and ABA](#)

### **Do session notes need to be signed by the client's caregiver?**

While it's not mandatory for session notes to be signed by the client's caregiver, obtaining a signature can serve as verification that treatment was provided.

References:

- [COMAR 10.09.28.04 F](#)
- Page 8: [ABA Provider Manual](#)
- [CASP Applied Behavior Analysis Co-Signature Requirements](#)
- [CASP Session Note Templates](#)
- [BHCOE Standard for the Documentation of Clinical Records for Applied Behavior Analysis Services](#)

### **What credentials should be included with a provider's signature? Is it sufficient to use abbreviations like "BCBA, LBA" or "RBT"?**

Yes, using abbreviations to indicate credentials and licensure, such as "BCBA," "LBA," or "RBT," is appropriate. Additionally, it is important to clearly indicate the role of each person signing to provide clarity on the role they played in the service rendered.

References:

- [COMAR 10.09.28.04 F](#)
- Page 8: [ABA Provider Manual](#)
- [CASP Session Note Templates](#)
- [BHCOE Standard for the Documentation of Clinical Records for Applied Behavior Analysis Services](#)

### **Can you clarify the feedback that transition or discharge criteria should not be solely based on assessment results, particularly concerning transition readiness?**

Transition and discharge plans should include the specific skills a client needs to successfully transition to a lower level of service and to be successful after discharge.

### **If we use our own treatment plan template, can we re-format some of the tables from your recommended template? Or do we need to make sure those tables are embedded exactly as displayed in your template?**

Yes, the provider may continue to utilize their own templates. Please ensure to add all the required fields into your template. Otherwise, adverse determination may result due to missing key information. For further support, please review:

- [Maryland Medicaid ABA Treatment Plan Requirements](#)
- [Maryland Medicaid ABA Treatment Plan Template Instructions](#)

## **Should graphical displays of treatment goal progress be included in the treatment plan report?**

As of 4/1/26 graphs are required for skill acquisition, behavior reduction and parent/caregiver goals. For further guidance, please review the Treatment Plan Guide.

References:

- [Maryland Medicaid ABA Treatment Plan Template Instructions](#)
- [Provider Alert: H2012 Discontinuation Reminder & Updated ABA Resources](#)
- [Maryland Department of Health Provider Training 2024](#)

## **Parental Consent**

### **If we obtain permission, can we sign consent forms on behalf of the client, parent, or caregiver?**

No, consent forms must be signed by the client, parent, or legal guardian. Obtaining permission to sign on their behalf is not sufficient, as the signature must come from the individual directly responsible for providing informed consent.

- Reference: [COMAR 10.09.28.04 A \(4\)](#)

### **In a multidisciplinary practice where providers from different disciplines treat the same client, is a Release of Information (ROI) required?**

We are unable to provide legal advice. Providers should review both state and federal regulations and guidelines to ensure their internal policies comply. Typically, individuals employed by the same company can share information for treatment purposes without requiring a Release of Information (ROI), as permitted under HIPAA rules. These rules allow for patient information sharing among providers within the same entity to facilitate treatment, payment, and healthcare operations.

### **We have parents sign the consent for treatment every six months. Can we include that in the session note, or do we need to ask the parent/client at the start of every session?**

Please review page 8 in the [ABA Provider Manual](#) for information related to documenting consent. Please note that the best practice is to obtain consent during each session, any time there is a change to the plan, including changes in interventions and/or at each reassessment/concurrent treatment request.

## Group Services

**Should group goals be clearly stated in the treatment plan when requesting group codes?**

Yes, group goals should be included in the treatment plan to meet medical necessity.

**For group sessions, is a Registered Behavioral Technician (RBT)/ Behavioral Technician (BT) required to be with each client, or can they be paired?**

For group sessions under the Maryland Medicaid ABA benefit:

- CPT Code 97154: This code is used when one RBT or Behavioral Technician is responsible for a group of participants, meaning multiple children can be attended to by a single RBT. It is crucial to demonstrate in the documentation that each participant is ready and medically suitable for learning in a group setting without requiring one-on-one RBT support. The sessions should concentrate on implementing social skill goals as specified in the treatment plan to address core challenges associated with an ASD diagnosis. It is important to note that the probing of new skills not included in the treatment plan is not covered under this code.
- CPT Code 97158: This code applies when a Board Certified Behavior Analyst (BCBA) leads a social skills group. In this scenario, the BCBA directs the implementation of the treatment plan. Unlike CPT code 97154, probing of skills yet to be addressed in the treatment plan may occur under this code. Supervision connected to code 97154 should be billed using CPT code 97155. It is necessary to ensure compliance with the requirement that at least 10% of all RBT hours (pertaining to both CPT codes 97153 and 97154) are supervised, which should be reflected in requests for CPT code 97155.

Reference:

- Page 44: [Maryland Department of Health Provider Training 2024](#)

## Discharge

### **If a client requests discharge, what is required in the discharge plan?**

Each provider may choose what information to relay in the discharge report, general information includes:

- Biopsychosocial information
- Summary of progress of skill acquisition, behavior reduction and caregiver goals
- Most current Behavior Intervention Plan (BIP)
- Reason for discharge (participant no longer meets criteria / goals have been met / parent is able to support the member outside of services / Parent withdraws from care / participant is not making progress or progress is no longer expected / services are no longer medically necessary)
- Next level of care (outpatient mental health services, medication management, mainstream school, etc.) o Linkages with other services
- How the family can contact the provider for additional assistance Community resources for the family
- Discharge date o Provider contact information

References:

- Page 33: [Maryland Department of Health Provider Training 2024](#)

### **Is there a requirement for both parent and clinician to sign the discharge report, or just the clinician?**

According to best practice guidelines and the BACB ethics code for behavior analysts (Code 3.15), behavior analysts are responsible for providing the client and/or relevant stakeholders with a written plan for discontinuing services, document acknowledgment of the plan, review the plan throughout the discharge process, and document all steps taken.

- Reference: [Ethics Code for Behavior Analysts: 3.15](#)

## **What steps should we take if a client is discharged on short notice and we are unable to obtain their signature on the discharge report?**

According to best practice guidelines and the BACB ethics code for behavior analysts (Code 3.15), behavior analysts are responsible for providing the client and/or relevant stakeholders with a written plan for discontinuing services, document acknowledgment of the plan, review the plan throughout the discharge process, and document all steps taken.

- Consider sending the discharge report to the client via mail or secure email. In your communication, request their signature and invite them to provide any additional feedback or questions they may have.
- Document the situation in the client's records, noting the reasons for the absence of a signature. Be sure to include details about any efforts made to obtain the signature, such as phone calls or attempted in-person meetings.
- Reference: [Ethics Code for Behavior Analysts: 3.15](#)

## **Should the most recent Behavior Intervention Plan (BIP) be included in discharge summaries, and is it recommended to provide this information to parents or caregivers?**

Yes, discharge reports should include reasons for treatment and discharge, collaboration details, progress on goals, behavior intervention plans, recommendations, resources, and follow-up activities. This ensures families can maintain skills or support continuity of care during transitions.

## **Should the discharge report be an updated treatment plan or a separate document?**

The discharge report can be an updated treatment plan, provided it includes necessary information such as the reason for treatment, reason for discharge, collaboration details if transitioning to another provider, progress on goals, behavior intervention plans, recommendations, resources, and follow-up activities. The discharge should ensure the family can maintain skills after treatment or support continuity of care if transitioning to another level of service or provider.

### **What steps should be taken if a client's family wishes to discontinue therapy or if providers decide to stop sessions, and is notification to Carelon required?**

A transition plan should be developed with the family to ensure a smooth discharge, setting them up for success post-treatment. If the client transitions to another level of service or provider, coordination of care should occur. A discharge report must be developed and provided to the family and submitted to Carelon within 30 days of discharge.

Reference:

- Page 33: [Maryland Department of Health Provider Training 2024](#)

### **Audits**

#### **Is the provider response time of 24 hours, 24 business hours, meaning Monday-Friday?**

Please respond to our outreach attempts within 24 business hours, Monday – Friday.

#### **Do CJIS background checks have to be through the company the services will be rendered through? Or can the provider obtain their own CJIS background check and provide it to the company? Can CJIS background checks from other companies be used?**

The company providing services to members must have a CJIS background check for all service providers. It is recommended that these checks are done by the company to ensure compliance. A provider may request their own CJIS background check or use one from another company, provided the company has internal policies on handling these checks.

Reference:

- Page 6 of [ABA Provider Manual](#)

#### **How do we demonstrate documentation of supervision?**

Documentation of supervision may be demonstrated through supervision notes for the months under review for each client. For more information on what is required check out our [ABA Quality Audit Tool](#) and [Quality Training on our website](#).

#### **What session notes are required to be submitted?**

Submit all session notes for services rendered on the specific dates listed in the chart request letter. Also, provide notes documenting supervision for the entire review period for each client and evidence of regular progress monitoring during that period.

#### **Is it necessary to have an attorney to initiate the appeal process?**

We are unable to provide legal advice or determine if having an attorney is necessary according to State laws or regulations.

- Reference: [COMAR 10.09.28.09](#)

### **What are the criteria for determining Recoupment or a PIP during an audit?**

After reviewing the submitted documents, and documenting compliance with COMAR requirements, auditors create a comprehensive report outlining their findings. This report is then issued to both the provider and MDH. MDH reviews and validates these audit findings to ensure they align with regulations and quality standards and decides on the necessary actions to promote quality improvement.

- Recoupment: Considered when documentation does not support the services billed on the claim.
- Performance Improvement Plan (PIP): Initiated when providers fail to meet compliance or quality standards.

### **How will documentation prior to the most recent changes be audited? Are older notes subject to the newest version of the manual?**

Records dated before January 1, 2025, will be audited based on the requirements that were in effect at the time of creation. However, the new standards will be referenced to inform providers of any changes in documentation requirements, ensuring that current and future records comply with the latest standards.

References:

- [ABA Provider Manual](#)
- [COMAR 10.09.28](#)
- [Maryland Medicaid ABA Service Codes Description](#)
- [Maryland Department of Health Provider Training 2025](#)
- [ABA Combination of Services Rule](#)

### **How will HR records be reviewed during an audit?**

During an audit, HR records will be reviewed for compliance with applicable regulations. The review process typically includes verifying the accuracy and completeness of employee information, documenting CJIS Background checks, ensuring proper documentation of employment activities, and checking for adherence to record-keeping requirements.

References:

- [ABA Provider Manual](#)
- [Maryland Medicaid ABA Service Codes Description](#)
- [COMAR 10.09.28](#)

### **What specific items can be marked for error and result in recoupment.**

Recoupment is determined by the Maryland Department of Health based on audit findings for items that do not meet the required standards.

### **What are auditors looking for to ensure that there is documentation that supports the services billed on the claim.**

- Organization information (Name, Address, Tax ID, NPI)
- Rendering provider information (Name, NPI, Provider Type, Eligible to provide services (Medicaid, BACB, State licensure, Age etc.))
- Member information (Name, DOB, Medicaid #)
- Date of service
- Place of Service
- Start/End times of service
- Service code
- Service description is a covered service and supports the code on the claim
- Modifier
- Consent to treatment (telehealth if applicable)
- Assessment/reassessment and treatment plan/progress report

### **What are the 4 findings codes on the billing review?**

- A: Documentation supports the code
- B: Documentation supports a different code
- C: Documentation does not support the code
- D: Documentation not provided

### **Will the claims that were reviewed and their findings be submitted with the audit findings?**

Yes, a billing discrepancy log will be attached to the audit report, detailing the claims that were reviewed and the auditor's findings.

### **What is the audit process?**

1. Provider Information Verification:
  - a. Carelon's ABA quality team will contact providers via email or phone to verify:
    - i. Tax ID
    - ii. Billing NPI
    - iii. Address
    - iv. Email to send chart request letter
    - v. Point of Contact (POC) for records or questions
    - vi. POC phone number

- b. Providers will be asked to create a secure password for protecting the chart request letter, which contains the charts needed for the audit.
  - i. Security Measures:
    1. An encrypted email will be sent where each recipient sets their own login information to access it.
    2. The document (the chart request letter) attached to the secure email will be encrypted using the password created during the verification process. This password will be used by anyone at the organization to access the document.
2. Chart Request Letter:
  - a. A chart request letter will be sent within 1-2 weeks, detailing the necessary charts for submission and information on submission and deadlines.
3. Receipt Confirmation:
  - a. Providers must confirm receipt of the chart request email within 24 hours.
4. Documentation Submission:
  - a. Providers have 10 business days from the letter's date to submit documentation. Extensions must be requested before the due date.
5. Audit Process:
  - a. The audit may take up to 30 days, depending on the number of records.
6. Audit Completion Report:
  - a. A report will be sent to MDH and the provider within 30 days of audit completion.
7. Letter of Determination:
  - a. Maryland Department of Health (MDH) will send a Letter of Determination (LOD) indicating findings and any further actions, such as recoupment, if needed.
8. Provider Response:
  - a. Providers have 10 days to respond to report errors, 15 days to submit a Program Improvement Plan (PIP) if required, and 30 days to appeal findings.

**Can you provide a list of the "Must Haves" and "Like to Haves" that were mentioned in the previous audit training?**

"Must haves" include:

Staffing:

- Staff roster:
  - Staff first and last name
  - Credentials
  - Employment dates
  - NPI number
  - Medicaid number
  - State licensure (if applicable) number
  - BACB certification number

- Employment verification
- CJIS background check
- OIG exclusion verification

#### Clinical Documentation:

- Consent to assessment and treatment for ABA services
- Consent to receive telehealth services
- Prescription for ABA services
- Comprehensive Diagnostic Evaluation (CDE)
- Individualized & comprehensive assessment
- Ongoing progress monitoring and treatment planning
- Documentation of each service delivered
  - The location, date, start time, and end time of the service;
  - A brief description of the service provided, including reference to the treatment plan;
  - A description of the participant's behaviors or symptoms in measurable terms;
- A description of the participant's parent or caregiver's participation in the ABA treatment sessions, including the parent or the caregiver's name and relationship to the participant, date, and time of participation or notification of the participant's parent or caregiver's consent to be absent; and
- A legible signature, along with the printed or typed name of the individual providing care, with the appropriate title.
- Documentation of supervision
- Ongoing supervision equals at least 10% of the number of direct treatment hours
- 25% of supervision occurs in person each month
- Claims are consistent with documentation of services delivered
- Organization information (Name, Address, Tax ID, NPI)
- Rendering provider information (First and Last Name and Credentials)
- Rendering provider is eligible to provide services (Medicaid, NPI, State Licensure, BACB Credential)
- Member information (Name, DOB, Medicaid #)
- Date of service
- Place of Service
- Start/End times of service
- Service code
- Service description is a covered service and supports the code on the claim
- Modifier
- Rendering provider signature with timestamp

#### Reference(s):

- [COMAR 10.09.28](#)
- [ABA Provider Manual](#)
- [ABA Quality Audit Tool](#)

**Is it acceptable to have OIG checks on a recurring schedule? Such as the first Monday of the month, which could be 29 or 32 days apart depending upon how dates fall?**

Yes, recurring OIG checks are acceptable as long as they occur on a monthly basis.

- Reference: [ABA Provider Manual](#)

**Can we submit an OIG verification report that includes all of our employees?**

It is not required to submit a report with all employees. Only include staff who rendered services to the identified members during the period being reviewed. You may include all employees but ensure that the relevant information is easily accessible to auditors.

**What is required to demonstrate compliance with OIG verification checks?**

OIG verification must be completed every 30 days and should include either the exclusion list from the OIG website, a screenshot/pdf of the online database search results, or a 3rd party report. It must include the staff's name and the date the search was conducted.

- Reference: [ABA Provider Manual](#)

**If certain documentation is partially illegible, should it be submitted in its original form, or would you prefer a clearer copy or rescan to support your review?**

Submit the original document along with any supplemental documentation that supports legibility and can be authenticated, such as a provider's attestation that the information is accurate, with a signature on the supplementary document.

**How should we submit the required documentation? How should the documents be named?**

Documents should be titled "Company Name\_Member/Staff Last Name\_Name of Document" (e.g. "Carelon\_Jones\_April Progress Notes").

Documents may be faxed to [866-890-0293](tel:866-890-0293) or emailed to [ABAQualityMD@carelon.com](mailto:ABAQualityMD@carelon.com). If you fax documents, send us an email to ensure we receive the records.

## Critical Incident / Sentinel Event Reporting

### **Do we have to use Carelon's incident form, or can we use our own internal incident form when reporting incidents?**

Providers can use their own incident form, provided it includes all the information required by our form. You can find a link to our form on page 12 of our provider manual. A link to our form is available on page 12 of the [ABA Provider Manual](#).

### **Can you provide more specific details about sentinel event reporting, including whether peer-on-peer injuries, elopements within a building, or minor injuries like bumps and trips should be reported?**

A Sentinel Event is defined as an unexpected occurrence that represents actual or the risk of serious harm of participants or to others by a participant who is in treatment. Sentinel Events are defined as any of the following:

- a) Death (suicide or unexpected) of a program participant
- b) A homicide that is attributed to a participant who, at the time of the homicide, was engaged in treatment at any level of care or was engaged in treatment within the previous 60 calendar days.
- c) Any serious or life-threatening injury to a participant when in a treatment setting resulting in urgent/emergent interventions. Serious injury specifically includes:
  - Loss of limb or function;
  - Non-consensual sexual activity, as prohibited in COMAR 10.01.18;
  - Any sexual activity between a staff member and a program participant;
  - Unexpected evacuation of a building under circumstances that threaten the life, health, or safety of participants;
  - Serious adverse reaction to behavioral health treatment requiring urgent or emergent medical treatment;
  - Injuries sustained during treatment, including accidental injuries;
  - Human Rights Violations (e.g., neglect, exploitation);
  - A serious physical assault of or by a participant, requiring urgent or emergent medical intervention that occurred on facility premises while the participant was receiving facility-based treatment.

Reference(s): [ABA Provider Manual](#)

## Claims & Billing

**We have a large number of claims still outstanding more than 90 days, significantly impacting our ability to work our A/R. When can we expect payment/resolution of these claims?**

For inquiries related to claims, contact our customer service at [1-800-888-1965](tel:1-800-888-1965).

**We have claims denying as "Duplicates" with claims submitted by other companies with the same date of service. How is this being rectified by Carelton as this is not something we can prevent, and it will prevent us from servicing our clients correctly?**

For inquiries related to claims, contact our customer service at [1-800-888-1965](tel:1-800-888-1965).

**When we obtain an auth from Anthem/Blue Shield, but Carelton is the carve-out, which fee schedule are we following?**

Carelton Behavioral Health Maryland administers the Maryland ABA program for participants under the age of 21 who are enrolled in the Medical Assistance Program through the Maryland Department of Health. If you obtain an authorization from Anthem/Blue Shield, please contact them to inquire about the applicable fee schedule. For any questions regarding Carelton Behavioral Health Maryland benefits, please reach out to our customer service department at [1-800-888-1965](tel:1-800-888-1965).

- Reference: [Maryland Carelton Behavioral Health ABA Providers](#)

**Can you explain what is meant by the rendering provider name must be on the claim?**

The claim must list the provider who delivered the service as the rendering provider. For example, if Suzie Jones provided 97153 services to Jay Jefferies on 1/16/26 from 9-11 am and completed the session note, then Suzie Jones must be listed as the rendering provider on the claim.

**Are we allowed to bill concurrently with an SLP**

Yes, when clinically justified. Please note that all services must be pre-authorized prior to rendering. Ensure that the medical necessity field in the treatment plan has a clinical rationale that is clear and thorough when services overlap.

**How long do you have to wait to bill for a reassessment?**

Providers may submit a concurrent treatment request within 30 days of their authorization expiring. For example, if the current authorization expires on May 15, 2025, providers may submit the request for concurrent treatment on/after April 15, 2025.

- Reference: [Authorization Parameters](#)

## **Can more than four hours of H2012 be used in a month as long as we don't go over the total number approved during the authorization?**

No, see code H2012 MDH ABA benefits, details and limitations:

- Maximum allowable of 4 units (1 hour) per day
- Maximum allowable of 16 units (4 hours) per month
- Maximum allowable of 96 units per 6-month authorization period
- Not eligible to be done via telehealth

CPT H2012 is no longer a covered code as of 2/1/2026. See [Provider Alert: H2012 Discontinuation Reminder & Updated ABA Resources](#).

## **Credentials & Licensing**

### **Carelon credentialing has requested CAQH access for providers for whom we have already granted access. Is there a good way to manage this effort in bulk?**

Carelon does not credential providers. To provide services to Medicaid members in Maryland, providers must first enroll in the Maryland Medicaid Program through ePREP. After registering with the Maryland Department of Health, providers can then register with Carelon to set up their *Availity* and *ProviderConnect* accounts.

NOTE: Maryland Medicaid will be [transitioning from ePREP](#), the current online provider enrollment and revalidation portal system, to a new Medicaid Provider Enrollment portal system set to go live in October 2026.

To prepare for the transition, Maryland Medicaid will be implementing a phased hold on ePREP applications. Once these holds take effect, providers must wait until the new system is available to make any enrollment updates, including new enrollments, revalidations, and any changes to existing enrollment accounts. Effective July 1, 2026, applications may not be submitted in ePREP for high and moderate risk provider types. A list of all high and moderate risk provider types is included in Attachment 1. Effective August 1, 2026, applications may not be submitted in ePREP for limited risk provider types. A list of all limited risk provider types is included in Attachment 2.

For any questions regarding this transmittal, please contact [mdh.providerenrollment@maryland.gov](mailto:mdh.providerenrollment@maryland.gov).

References:

- [Provider Bulletin: 2.6.26 & PT59-26-Provider-Enrollment-Portal-Transition](#)
- [Maryland Carelon Behavioral Health ABA Providers](#)

### **Does the behavioral health administration licensing application need to be done for ABA providers?**

Please review page 5 in the [ABA Provider Manual](#) for information related to enrollment.

## **Do you need a specific authorization for Board Certified Assistant Behavior Analyst (BCaBA) services?**

Authorizations will be provided under the ABA provider group. The ABA provider group must be a participating provider with the program. Any rendering provider under the ABA provider group should also be a participating provider with the program (registered in ePREP). Please review page 5 of the [ABA Provider Manual](#) for information related to enrollment.

## **How can Licensed Psychologists be added to your network if they are already enrolled in ePREP under mental health?**

Please review page 5 in the [ABA Provider Manual](#) for information related to enrollment.

## **We are looking to become an ABA provider in the future. However, we have recently learned about Play Project – does Medicaid cover that service?**

Treatment modalities outside of ABA will not be reviewed by the ABA Utilization Management department nor be billed under ABA service codes. Please contact the Maryland Department of Health via [MDH.ABA@maryland.gov](mailto:MDH.ABA@maryland.gov) and BHA to obtain information related to what other services other than ABA may be covered.

## **Continuity of Care**

### **If provider A cuts off services because a parent asks for the Continuity of Care form, what is provider B supposed to do?**

If provider A discontinues services, there should be a discharge report or date on file. Should the system still display an active authorization for Provider A, Provider B will need to secure a parent/guardian's note. This note will serve as a documented request to amend the authorization and allow Provider B to initiate services. Providers A and B must adhere to any applicable regulations and guidelines regarding transitions in care to ensure compliance and continuity of services for the client.

References:

- [Continuity-of-Care-Initial-Assessment-Request.pdf](#)
- Page 27 of [Maryland Department of Health Provider Training 2024](#)

### **Is there a way for providers to know if there is an additional provider rendering services prior to requesting authorization?**

Providers are encouraged to ask the family during the intake process if they have an active authorization with another ABA agency. If the family shares that they do, please submit a completed Continuity of Care Form. Please know that a parent note is also required to approve the request for an initial assessment for the second provider.

References:

- [Continuity-of-Care-Initial-Assessment-Request.pdf](#)
- Page 27 of [Maryland Department of Health Provider Training 2024](#)

## Referrals

**Do we have to use the Carelon referral form, or can we use any referral from the QHCP, such as a prescription pad?**

No, the QHCP may use their prescription pad, and/or may provide a letter or statement recommending ABA services. Please note that when requesting an initial assessment, the ABA recommendation must be within 6 months of the request.

References:

- Page 7 of [Maryland Department of Health Provider Training 2024](#)
- [7.8.25-Initial-Concurrent-ABA-Authorization-Request-Requirements](#)

## School-Based Services

**What services are allowed to be rendered in a public school?**

Provision of ABA services during school hours is not the standard model of the Maryland Medicaid ABA benefit. ABA is not intended for RBTs/BTs to function as school aides or provide academic instruction.

School-based ABA services are considered short-term and must be clinically justified. Schools are responsible for providing appropriate educational placements, accommodations, and supports through the IEP or 504 process.

An RBT/BT may not serve as a 1:1 educational aide. School placements requiring families to supply support staff as a condition of enrollment do not meet medical necessity criteria for ABA approval under Carelon Maryland.

Services in the school setting may be appropriate under the following circumstances:

- Need for generalization of previously mastered objectives to a different setting.
- Need for specialized ABA intervention to support school personnel in the reduction of challenging behaviors not occurring in other settings and that interfere with full participation in the classroom.

**I was under the impression that POS 3 is for K-12, and does not include Pre-K, is that correct?**

If the participant is attending a Pre-K program that is funded with federal, state, or local government funds, the POS is 3. If it is a private setting, such as daycare, the POS will be 12.