Optum

Medical Records Documentation for Reviews of Applied Behavior Analysis (ABA) Services

This protocol lists medical records documentation used and which may be required, when applicable for reviews. This medical record documentation content was developed in an effort to decrease the need for repeated requests for additional information and to provide guidance on administrative documentation requirements. We reserve the right to request more information, if necessary. Medical record documentation content used for review(s) may vary among various UnitedHealthcare and External benefit plans. This content is provided for reference purposes only and may not include all services or codes. Listing of a service or code in this protocol does not imply that it is a covered or non-covered health service or code. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws. This protocol is the property of Optum Behavioral Health Solutions and unauthorized copying, use or distribution of this information is strictly prohibited. It is regularly reviewed, updated and subject to change. Where state law, Medicaid requirements, or member-specific benefit plans impose different or less restrictive documentation standards, those standards control.

Service	Medical Records Guidelines Used for ABA Reviews
General (required for all ABA services in addition to the specific elements outlined by services below)	1. Documentation must be sufficient to independently validate the total billable time reported, including but not limited to recorded session start and stop times, where required by payer policy. 2. The medical record should be complete and legible. 3. All addendums, late entries and corrections should follow CMS guidelines, including: • The date of signature must reflect the date the note is finalized. If the signature is completed after the date of service, the entry should comply with late entry requirements and clearly indicate the date the note was signed. 4. Daily progress notes should include: Place of Service (POS); the specific service, who attended the session, and signature of the rendering provider 5. Legible identity of the rendering provider with credentials
Behavior Identification Assessment (97151)	The documentation for each patient encounter should include: • First and last name of the member • Diagnosis • Date of Service • Place of service • Legible identity of the provider with credentials • Actual start and actual stop times • Comprehensive Assessment including (at least one or more of the following):

	○ Direct observation ○ Record review/analysis of past data ○ Administration, scoring, and/or analysis of assessment tools ○ Preparation of report/treatment plan ○ Discussion with caregivers • Narrative/Session summary
Behavior Identification Assessment (97152)	The documentation for each patient encounter should include: • First and last name of the member • Diagnosis • Date of Service • Place of service • Legible identity of the provider with credentials • Actual start and actual stop times • Assessment including (at least one or more of the following): ○ Observation of the client face to face ○ Data collection for the assessment • Narrative/Session summary
Adaptive Behavior Treatment by Protocol (97153)	The documentation for each patient encounter should include: • First and last name of the member • Diagnosis • Date of Service • Place of service • Legible identity of the provider with credentials • Actual start and actual stop times • Face to face therapeutic session focused on developing a skill or reducing a behavior • Interventions applied • Data summary • Narrative/Session summary
Group Adaptive Behavior Treatment by Protocol (97154)	The documentation for each patient encounter should include: • First and last name of the member • Diagnosis • Date of Service • Place of service • Legible identity of the provider with credentials • Actual start and actual stop times • Face to face therapeutic group session focused on developing a skill or reducing a behavior • Interventions applied • Data summary per patient

	• Narrative/Session summary • Indication of 2 – 8 participants

Adaptive Behavior Treatment with Protocol Modification (97155)	The documentation for each patient encounter should include:
	
	• First and last name of the member
	• Diagnosis
	• Date of Service
	• Place of service
	• Legible identity of the provider with credentials
	• Actual start and actual stop times
	• Participants identified, including technician and their credentials, **if** present
	• Protocol modification changes (or indication that no changes occurred)
	• Narrative/Session Summary including:
	  ○ observations
	  ○ direction given to a technician, if applicable, as they delivered ABA services

Family Adaptive Behavior Treatment Adaptive Guidance (97156)	The documentation for each patient encounter should include: • First and last name of the member • Diagnosis • Date of Service • Place of service • Legible identity of the provider with credentials • Actual start and actual stop times • Identification of caregiver(s) who attended and relationship to the patient • Presence or absence of the client • Evidence of teaching behavior strategies to the caregiver • Goals/Program(s) implemented • Data Summary • Narrative/Session Summary
Multiple-family Group Adaptive Behavior Treatment Guidance (97157)	The documentation for each patient encounter should include: • First and last name of the member • Diagnosis • Date of Service • Place of service • Legible identity of the provider with credentials • Actual start and actual stop times • Identification of caregiver(s) who attended and relationship to the patient • Indication of 2 – 8 participants

	• Evidence of teaching behavior strategies to the caregiver • Goals/Program(s) implemented • Narrative/Session summary • Data Summary per patient • Interventions applied
Group Adaptive Behavior Treatment with Protocol Modification (97158)	The documentation for each patient encounter should include: • First and last name of the member • Diagnosis • Date of Service • Place of service • Legible identity of the provider, qualified clinician with credentials • Actual start and actual stop times • Interventions applied • Indication of 2 – 8 participants • Face to face therapeutic group session focused on developing a skill(s) or reducing a behavior(s) • Narrative/Session summary • Data Summary per patient • Protocol modification changes (or indication that no changes occurred)

Behavior Identification supporting assessment (0362T) each 15 minutes of technicians' time face-to face with a patient, requiring the following components	The documentation for each patient encounter should include:
	
	• First and last name of the member
	• Diagnosis
	• Date of Service
	• Place of service
	• Legible identity of both technicians with credentials
	• Actual start and actual stop times
	• Customizations made to the environment specific to destructive behavior
	• Name of the Qualified Health Professional (QHP)
	• Narrative/Session Summary including (at least one of the following):
	  ○ Face to face observation of the client
	  ○ Face to face assessment
	• Destructive behavior(s)
	• Data collection

Adaptive Behavior Treatment with Protocol Modification (0373T) each 15 minutes of technicians' time face-to-face with a patient, requiring the following components	The documentation for each patient encounter should include: • First and last name of the member • Diagnosis • Date of Service

	• Place of service
	• Legible identity of the provider with credentials
	• Actual start and actual stop times
	• Name of the QHP
	• Legible identity of the other provider(s) with credentials
	• Customizations made to the environment specific to destructive behavior
	• Narrative/Session Summary including (at least one of the following):
	  ○ Face-to-face observations
	  ○ Face-to-face direction was given to a technician as they delivered ABA services
	• Destructive behavior(s)
	• Goals/Program(s) implemented
	• Summary of data reported
	• Identification of person who recorded the data
	• Interventions applied

CMS Counting Minutes in Timed Codes

Counting Minutes for Timed Codes in 15 Minute Units: Time intervals for 1 through 8 minutes are as follows:	
1 Units	≥ 8 minutes through 22 minutes
2 Units	≥ 23 minutes through 37 minutes
3 Units	≥ 38 minutes through 52 minutes
4 units	≥ 53 minutes through 67 minutes
5 units	≥ 68 minutes through 82 minutes
6 units	≥ 83 minutes through 107 minutes
7 units	≥ 108 minutes through 132 minutes
Please Note: The pattern remains the same for treatment times in excess of 2 hours.	

Resources

- ABA Coding Coalition (abacodes.org) Frequently Asked Questions | ABA Coding Coalition
- The Council of Autism Service Providers (CASP)
- Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
- Behavioral Health Services National Provider Network Manual

History

June, 2026	Implementation of ABA Documentation Protocol Document