

ABA Training

Recent Changes to Forms

Billing Process

Common Billing Issues

Recent Changes to Forms

- ❖ ABA Intent to Initiate
- ❖ Additional Units of Service Form
- ❖ ABA Provider Transfer Request
- ❖ Telehealth Exception Form



Applied Behavior Analysis (ABA) Services Intent to Initiate Treatment

ABA Intent to Initiate Treatment form

Providers must complete this form to notify the Department of the intent to initiate services.

DDP will also retroactively reimburse for services.

This form notifies DPHHS of the intent to initiate Applied Behavior Analysis (ABA) services for a member with a provisional qualifying diagnosis as delineated in the Eligibility Criteria and who meets Functional Impairment Criteria. DPHHS is unable to reimburse a provider for services rendered unless this form is completely and accurately filled out and submitted. Please send all required information and documentation to via the secure Montana File Transfer Service at <https://transfer.mt.gov> to DDPServiceRequest@mt.gov.

Provisional Qualifying Diagnosis

- Autism Spectrum Disorder*
- Serious Emotional Disturbance*
- DD Eligible**

*Any physician, licensed mental health professional, or qualified healthcare professional may refer a member for the initiation of ABA services under these provisional qualifying diagnoses. However, to be eligible for re-authorization of ABA services, the provisional qualifying diagnosis must have been established a qualified healthcare professional with expertise in the diagnostic area.

**Any member being served with a qualifying diagnosis of Developmental Disability must have been deemed eligible for the receipt of state-sponsored developmental disabilities services.

Date of Submission _____

Member Name _____

Date of Birth _____

Medicaid Card ID _____

Parent or Guardian/Caregiver Name _____

Parent or Guardian/Caregiver Contact Information _____

Provider Name _____

Provider Contact Information _____

Provider NPI _____

Provider License Number _____

Start Date for Services _____

Enter the first date of service, which may pre-date the Date of Submission

ABA Intent to Initiate Form

When you submit the Intent to Initiate Treatment form at <https://transfer.mt.gov> to DDPSERVICERequest@mt.gov, you can expect to hear back via email after the form is processed. In this email, you will receive the begin and end date of the billing span. No PA will be required during this billing span.

Hello,

This email is to confirm that your request to initiate ABA services for member##### was received. For the initial 180 days, **01/02/2023 – 07/01/2023**, services can be billed without a prior authorization number. To continue services after 07/01/2023, you will need to submit a request for continuation of services through Qualitrac.

<https://www.mpqhf.org/corporate/medicaid-portal-home/>

Review manuals, fee schedules and more at <https://medicaidprovider.mt.gov/76>.

Please let me know if you have any questions or concerns,

Thank you

ABA Additional Units Request form

This form must be submitted with:

- ❖ The Treatment Plan
- ❖ Behavior Identification Assessment, and
- ❖ One of the following:
 - A Diagnostic Evaluation (for members with an ASD or SED Provisional Diagnosis), or
 - Proof of DD Eligibility, or
 - An annual Clinical Re-Assessment (Only for members with SED)

This form notifies the Department of the intent to continue Applied Behavior Analysis (ABA) services beyond the initial or previously authorized 180 calendar days or 1,260 units of service for a member with a qualifying diagnosis and who meets the Functional Impairment and Eligibility Criteria.

The Department is unable to reimburse a provider for services rendered unless this form is completely and accurately filled out and submitted. Reimbursement may not be given retroactively for failure to submit timely, complete and required documentation. Please upload forms/documentation to Qualitrac via the Medicaid Utilization Review Portal [Medicaid Portal - Home - Mountain-Pacific Quality Health \(mpqhf.org\)](https://www.mt.gov/medicaid-portal).

Date of Submission _____

Member Name _____

Date of Birth _____

Medicaid Card ID _____

Parent or Guardian/Caregiver Name _____

Parent or Guardian/Caregiver Contact Information _____

Provider Name _____

Provider Contact Information _____

Provider NPI _____

Provider License Number _____

Start Date for Services _____

By signing below, the service provider confirms in writing all of the following:

A qualified healthcare professional with expertise in the diagnostic area* has performed a Diagnostic Evaluation which has confirmed the qualifying diagnosis and the professional deems the service medically necessary to ameliorate the symptoms of the stated qualifying diagnosis.

*To be eligible for re-authorization of ABA services, the provisional qualifying diagnosis must have been established by one of the following qualified healthcare professionals with expertise in the diagnostic area:

- Child and adolescent psychiatrist
- General psychiatrist with child and adolescent experience
- Psychiatric mental health nurse practitioner with child and adolescent experience
- Developmental pediatrician
- Neuropsychologist/psychologist

The licensed Board Certified Behavior Analyst (BCBA) delivering services has confirmed in writing the continued medical necessity of the service and the expectation that the member's presenting deficits will continue to improve to a clinically meaningful extent.

Qualified Diagnosis

Page two of the Required Document Components checklist gives examples of what counts as a qualified diagnosis.

Diagnostic Evaluation

Applies only to Autism Spectrum Disorder (**ASD**) and Serious Emotional Disturbance (**SED**) provisional qualifying diagnoses.

- 1. Performed by qualified health care professional with expertise in the diagnostic area
- 2. Establishes qualifying diagnosis
- 3. Indicates medical necessity of ABA services to ameliorate symptoms of the qualifying diagnosis
- 4. Documents the Functional Impairment Criteria met by the member at the time of evaluation

Clinical Re-Assessment

Required annually and applies only to SED.

- 1. Confirms qualifying diagnosis from Diagnostic Evaluation
- 2. Indicates medical necessity of continued ABA services to ameliorate symptoms of the qualifying diagnosis
- 3. Documents the Functional Impairment Criteria met by the member at the time of re-assessment

DD Eligibility

Applies only to individuals being served under a Developmentally Disabled (DD) Eligible category.

- 1. DD eligibility letter confirming the individual has been determined eligible; or
- 2. Evaluation Determination Stand-Alone document from Care Management System with state review section affirming person is eligible for Montana Milestones Part C or Family Education and Support Services, dated within 365 days.

ABA Provider Transfer Request Form

When you submit the Provider Transfer Request form, enter the total number of units used so that providers know how many units are remaining.



Applied Behavior Analysis (ABA) Services Provider Transfer Request

Please complete the form in its entirety and send via the secure Montana File Transfer Service at <https://transfer.mt.gov> to DDPServiceRequest@mt.gov.

Member Information

Member Name _____
Date of Birth _____
Medicaid Card ID _____

Provider Information

Agency Name and Contact Person _____
Telephone Number _____
Email Address _____

Current Authorization Information

Current Authorization Start and End Dates _____
Prior Authorization Number (if applicable) _____

Number of Units Used _____

Authorization Transfer Request

The end date of the amendment will be the same as the current authorization end date.

Anticipated Date of Requested Transfer _____

This transfer is requested to split hours of the current authorization with another provider.

OR

This transfer is requested to transition the entire amount of the current authorization to the provider requesting this change.

Justification for Transfer

Signatures

Both the original provider **and** additional provider must sign this amendment.

ORIGINAL Authorized Provider Printed Name _____

Signature and Credentials _____ Date _____

ADDITIONAL Requested Provider Printed Name _____

Signature and Credentials _____ Date _____

ABA Telehealth Exception Request Form

The Public Health Emergency is set to end May 11th, 2023.

After that time, providers must complete this form for prior authorization of services to be delivered via Telehealth.



Applied Behavior Analysis (ABA) Telehealth Exception Request

Complete this form for prior authorization of services to be delivered via telehealth.

Save and submit the completed form to [HHS DSD DDP Service Request \(ddpservicerequest@mt.gov\)](mailto:ddpservicerequest@mt.gov) via the [Montana State File Transfer Service](#).

Practitioners should be familiar with and adhere to the guidelines as specified in the Council of Autism Service Providers (2021). [Practice Parameters for Telehealth-Implementation of Applied Behavior Analysis: Second Edition](#). Wakefield, MA: Author.

Date of Submission	
Member Name	
Member DOB	
Member Medicaid Card ID	
BCBA Name and Contact Information	
BCBA NPI and License Number	
Anticipated start date for this request	
Initial Request <input type="checkbox"/>	Renewal Request <input type="checkbox"/>
Describe the specific reason for this request.	
Clearly identify why ABA Telehealth delivery is medically necessary for this member	
Describe the patient characteristics that support the use of ABA Telehealth	
Identify which, if any, goals and objectives in the Treatment Plan are not suitable for ABA Telehealth.	

All ABA forms can be found at <https://medicaidprovider.mt.gov/76> as well as previous ABA trainings.

By clicking on the designated buttons on the right, a drop-down menu will appear with all the forms or trainings.

Applied Behavior Analysis Services

[Prior Authorization](#)

[Forms](#)

Provider Manuals

Medicaid Rules and Regulations

Fee Schedules - Applied Behavior Analysis Services

Provider Notices

Forms

ABA Trainings

Other Resources

Billing Process

- ❖ Creating Templates in MPATH
- ❖ Submitting Claims in MPATH

Claim Submission Templates

This function is a time saving tool for reoccurring claims.

Example:

You see the same member for the same service on a consistent basis. You can create a template for that member with all the claim information that remains the same over time.

When it is time to submit their claim; select the billing provider NPI & Rendering Provider NPI (if applicable). Enter any additional required information on the Claim Information screen. Submit your claim.

Creating a Template

To create a template, select the **Claims Submission Templates** tab.

Click the **blue button** for the claim form required.

Claim Submission Templates ? Help

Maximum Templates Allowed : 500 Filter your results:

Actions	Name	Date Last Modified
 	Member B	12/08/2021
 	Ortho	12/09/2021
 	Test 121	12/01/2021
 	Tester22	12/15/2021

Show entries Showing 1 to 4 of 4 templates [|](#) [<](#) [>](#) [|](#)

[Create Professional Claim Submission Template](#)

[Create Facility Claim Submission Template](#)

[Create Dental Claim Submission Template](#)

Creating a Template

Enter the member's MT Medicaid ID number.

Click **Search**.

When the member information populates, verify and click **Save and Continue**.

Professional Claim Template

Help

Member Details

Enter Member Card ID:



Creating a Template

Complete the fields that will not change.

For instance, the diagnosis code, CPT code, modifier & diagnosis point fields will most likely not change for reoccurring visits.

Professional Claim Submission Form ? Help

Claim Information

Note : Fields marked with an asterisk * are required.

Note : Do not include any decimals when entering Diagnosis Code information. Enter at least first three (3) characters of a Diagnosis and/or Procedure code before utilizing the search icon.

Diagnosis Codes

Diagnosis Codes (ICD 10):

1 *	2	3	4	5	6
<input type="text"/>					
7	8	9	10	11	12
<input type="text"/>					

Claim Details

Note :  indicates all required fields of COB have been entered.

From Date*	To Date*	POS*	CPT/ HCPCS Code*	Modifier	Diagnosis Pointer*	Charges*	Days or Units*	COB	NDCEPSDT	Emergency Service	Family Planning
<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>			\$		COB		<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>			\$		COB		<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>			\$		COB		<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>			\$		COB		<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>			\$		COB		<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>			\$		COB		<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>			\$		COB		<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>			\$		COB		<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>			\$		COB		<input type="checkbox"/>	<input type="checkbox"/>

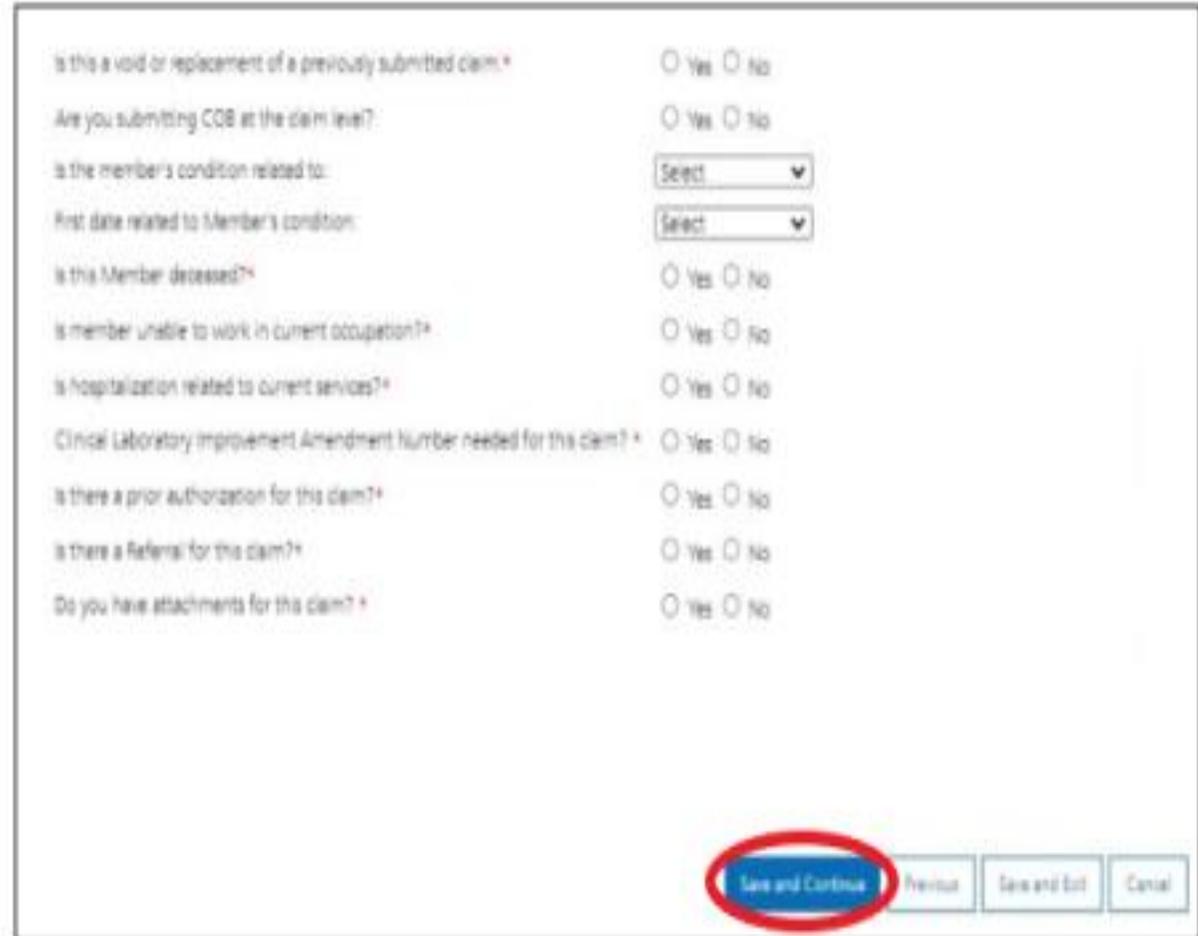
Total Charges: \$

Creating a Template

Answer all the questions at the bottom of the screen.

If your claim requires a Prior Authorization, make sure you add that number to your template.

Click **Save and Continue**.



The screenshot shows a form with the following questions and options:

- Is this a void or replacement of a previously submitted claim? Yes No
- Are you submitting COB at the claim level? Yes No
- Is the member's condition related to:
- First date related to Member's condition:
- Is this Member deceased? Yes No
- Is member unable to work in current occupation? Yes No
- Is hospitalization related to current services? Yes No
- Clinical Laboratory Improvement Amendment number needed for this claim? Yes No
- Is there a prior authorization for this claim? Yes No
- Is there a Referral for this claim? Yes No
- Do you have attachments for this claim? Yes No

At the bottom right, there are four buttons: **Save and Continue** (highlighted with a red circle), Previous, Save and Exit, and Cancel.

Creating a Template

The last step is to name the template. Then click **Save**.

Your template is now visible.

To submit a claim, click on the **Name**.

To edit a template, click on the **Pencil** icon.

To delete a template, click on the **Garbage can** icon.

Facility Claim Template

Save Template

Please enter a claim submission template name.

Template Name: *

Note(s):

Template Name must satisfy the following conditions:

- a. Minimum length: 3 characters.
- b. Maximum length: 35 characters.
- c. Cannot contain special characters other than: Space " " or Underscore "_" or Dash "-".

Submit

Previous

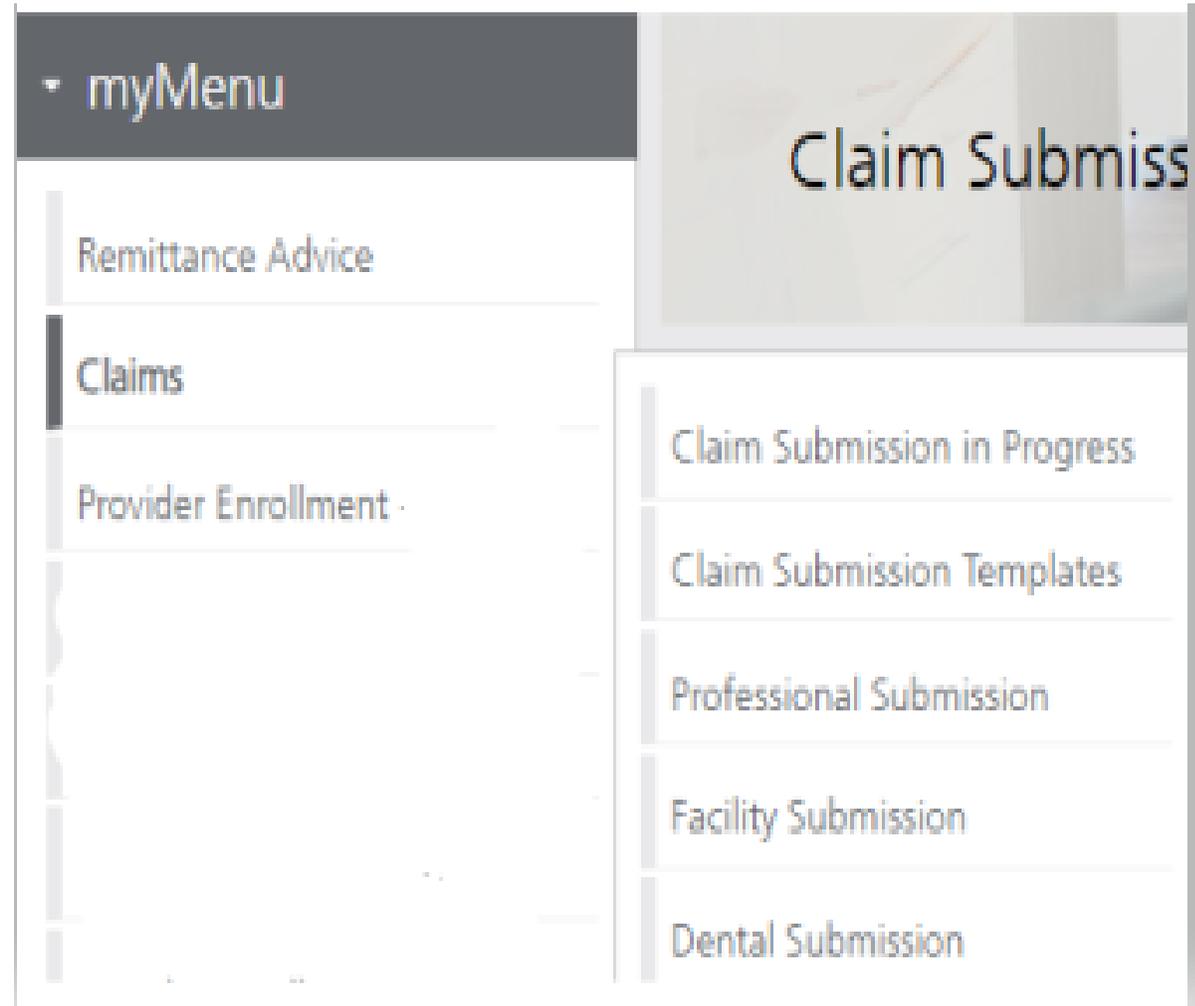
Cancel

Actions	Name	Date Last Modified
 	<u>Member B</u>	12/08/2021
 	<u>Ortho</u>	12/09/2021
 	<u>Test 121</u>	12/01/2021
 	<u>Tester22</u>	12/15/2021

Submitting a Claim

To submit a claim using a template, place your cursor on the **Claims** tab.

Select **Claim Submission** type for one-time claims or **Claim Submission Templates** to submit a claim from a template.



Submitting a Claim – Billing Provider Screen

Select the Billing Provider file.

If you have multiple NPIs listed under Manage Billing Providers, the NPI/API field will have a drop down.

Select NPI.

Select Program/Waiver.

Select Specialty.

Click **Save and Continue**.

NPI/API: *	1245490713	NPI/API: *	1033508080
Provider Name: *	NORTH WEST HOME CARE	Provider Name: *	LIBERTY PLACE, INC
Program/Waiver: *	Montana Medicaid (HMK Plus) v	Program/Waiver: *	Severe Disabling Mental Illness Waiver (SDMI) v
Specialty: *	In Home Supportive Care v	Specialty: *	Select Program/Waiver
Service Location Address 1: *	818 W CENTRAL	Service Location Address 1: *	Severe Disabling Mental Illness Waiver (SDMI)
Service Location Address 2:		Service Location Address 2:	Big Sky Waiver
City: *	MISSOULA	City: *	BOOTSTRAP RANCH E
State: *	MT	State: *	BELGRADE
ZIP: *	59801-0000	ZIP: *	MT
Taxonomy Code: *	253Z00000X	Taxonomy Code: *	59714-8121
Enrollment Unit: *	0000262208	Enrollment Unit: *	251S00000X
			0000801034

Submitting a Claim – Billing Provider Screen

If the Billing file you chose requires a Rendering Provider, the Rendering Provider drop down will appear.

Select your rendering NPI from the dropdown.

*Rendering providers must be affiliated to the billing NPI, to appear in the dropdown

Click **Save and Continue**.

- Billing Provider

Note : Fields marked with an asterisk * are required.

NPI/API:*	1316521222
Provider Name:*	WHICKER GROUP
Program/Waiver:*	Montana Medicaid (HMK Plus)
Specialty:*	Single Specialty
Service Location Address 1:*	2600 WILSON ST STE 4
Service Location Address 2:	
City:*	MILES CITY
State:*	MT
ZIP:*	59301-5094
Taxonomy Code: *	193400000X
Enrollment Unit:*	0000734214

Rendering Provider

NPI:*	<div style="border: 1px solid black; padding: 2px;"><p>Select NPI</p><p>1609484575</p><p>1538253760</p><p>1164561635</p></div>
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Referring Provider

There is a referring provider for this claim.

Ordering Provider

There is a ordering provider for this claim.

Submitting a Claim

If the Billing file you chose, requires a Team number.

(CSCTs & some waiver programs)

Select Team number.

Click **Save and Continue**.

Note : Fields marked with an asterisk * are required.

NPI/API: *	<input type="text" value="1497871255"/>
Provider Name: *	<input type="text" value="EXPRESS PERSONNEL S"/>
Program/Waiver: *	<input type="text" value="Developmentally Disabled Waiver (DDP) ▼"/>
Specialty: *	<input type="text" value="Nursing Care"/>
Service Location Address 1: *	<input type="text" value="3709 BROOKS ST"/>
Service Location Address 2:	<input type="text"/>
City: *	<input type="text" value="MISSOULA"/>
State: *	<input type="text" value="MT"/>
ZIP: *	<input type="text" value="59801-7334"/>
Taxonomy Code: *	<input type="text" value="251J00000X"/>
Team Number: *	<input type="text" value="TEAM 01"/>
Enrollment Unit: *	<input type="text" value="0000623934"/>

Submitting a Claim

Enter the member's MT Medicaid ID number.

Click **Search**.

When the member information populates, verify you have the correct member.

Click **Save and Continue**.

Professional Claim Template

Help

Member Details

Enter Member Card ID:

Submitting a Claim

Complete all required fields and questions.

Required information is denoted with a red asterisk *

Professional Claim Submission Form ? Help

Claim Information

Note : Fields marked with an asterisk * are required.

Note : Do not include any decimals when entering Diagnosis Code Information. Enter at least first three (3) characters of a Diagnosis and/or Procedure code before utilizing the search icon.

Diagnosis Codes

Diagnosis Codes (ICD 10):

1 *	2	3	4	5	6
<input type="text"/>					
7	8	9	10	11	12
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Claim Details

Note :  indicates all required fields of COB have been entered.

From Date*	To Date*	POS*	CPT/ HCPCS Code*	Modifier	Diagnosis Pointer*	Charges*	Days or Units*	COB	NOC	EPSDT	Emergency Service	Family Planning
<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>			\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>			\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>			\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>			\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>			\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>			\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>			\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>			\$		COB			<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	Select ▼	<input type="text"/>			\$		COB			<input type="checkbox"/>	<input type="checkbox"/>

Total Charges: \$

Submitting a Claim

Complete all required fields and questions.

Required information is denoted with a red asterisk *

Click **Save and Continue**.

The screenshot shows a form with the following questions and options:

- Is this a void or replacement of a previously submitted claim? * Yes No
- Are you submitting COB at the claim level? Yes No
- Is the member's condition related to:
- First date related to Member's condition:
- Is this Member deceased? * Yes No
- Is member unable to work in current occupation? * Yes No
- Is hospitalization related to current services? * Yes No
- Clinical Laboratory Improvement Amendment Number needed for this claim? * Yes No
- Is there a prior authorization for this claim? * Yes No
- Is there a Referral for this claim? * Yes No
- Do you have attachments for this claim? * Yes No

At the bottom right, there are four buttons: **Save and Continue** (circled in red), Previous, Save and Exit, and Cancel.

Common Errors

- ❖ Common Billing Errors
- ❖ Common Documentation Errors

Common Billing Errors

- Intent to Initiate Treatment form not completed
- Billing past 180 days or 1260 units (whichever comes first) without a PA
- Billing more units per date of service than allowed
- Missing/Invalid information
- Prior Authorization number missing or invalid
- Exact duplicate
- Proc. Code not covered/not allowed for Provider Type
- Recipient not eligible DOS
- Using the incorrect modifier for a provider type

Common Documentation Issues

Non-Clinical Errors

- Personal Representative Panel not Completed
- Request for Additional Units of Service incomplete or not submitted
- Incorrect start date on Request for Additional Units of Service form (must be start date of requested span)
- Missing diagnostic evaluation for the initial Additional Units of Service request
- Requests that should be continued stay reviews (CSRs) are opened as new cases, rather than a CSR from a previously approved case.

Clinical Errors

- Lack of parent goals or parent goals written incorrectly
- Coordination of care is missing
- Missing baseline data
- Missing data/graphs/tables from assessments

Resources

For more training on billing, you may visit

<https://medicaidprovider.mt.gov/docs/training/2022Training/Billing101Training07212022.pdf>.

For generic questions about billing, you may email MTPRhelpdesk@Conduent.com.

For specific questions about billing, you may email MTEnrollment@conduent.com.

You may also call Provider Relations at 1 (800) 624-3958 Opt. 7, Opt. 2

Note. Provider Relations cannot tell you what/how to bill. They can only explain required information and denial reasons.

You may also visit <https://medicaidprovider.mt.gov/76> for additional ABA trainings.

Questions?