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Behavioral Health Lunch & Learn — Autism Documentation Guidelines

Q&A from Nov. 18, 2025, event

For Blue Cross commercial, Medicare Plus Blue℠, Blue Care Network commercial and BCN Advantage℠

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This document contains answers to questions that were asked during or as a result of the November 18, 2025, lunch & learn webinar.

Progress note requirement

Regarding the requirement "*each progress note is limited to two hours and thirty minutes (2:30) elapsed time duration*" due to the 15-minute interval structure:

Q1. Does this mean all progress notes must now use full 15-minute intervals or are services still billed according to the eight-minute rule?

A. Yes, all progress notes for ABA must be documented in 15-minute intervals at a max of 10 units (2.5 hours). Services are not billed for ABA using an eight-minute rule. The 50% rule does not apply to this code.

Q2. Is 2.5 hours the daily maximum for *97153?

A. No, it only relates to the maximum time that can be covered by the documentation of one progress note of 10 units of ABA (2.5 hours).

Q3. Can a client receive more than 2.5 hours of *97153 in a single day if the same provider begins a new note or if a different provider steps in after the first 2.5 hours (creating a separate progress note)?

A. 2.5 hours is NOT a daily maximum of ABA (*97153) treatment hours per day. 2.5 hours (10 units) is the max for documenting each progress note for ABA. This guideline is not limited to requiring a different provider to “step in” and do more ABA. ABA “total” hours per day are guided by what has met medical necessity and been authorized by Blue Cross Behavioral Health (e.g. 25 hours per week; member comes to center five days = five hours per day). This would require two progress notes each day for ABA for five hours total.

Regarding signatures

Q4. Can you confirm whether the BT/RBTs signature is required on parent-training and supervision notes?

A. If they participate in providing direct service, yes.

Q5. If so, could you clarify the reason for this requirement?

A. Standard clinical practice. The person providing the direct care needs to be identified. Documentation also needs to be signed by the LBA as the supervising/billing practitioner who is taking full responsibility for the actions and interventions of the person they are supervising. Supervision/protocol modification notes provided by an LBA must be signed by the LBA. If an LBA is providing caregiver training, the RBT is not required to attend. However, if they do attend and participate, the RBT and LBA must both sign.

Regarding the requirement that the analyst must also sign the *97153 notes

Q6. If the LBA on the case is on PTO, can a different LBA review and sign the note, or does it need to wait for the supervising analyst assigned to the case to return?

A. The LBA that is actually providing the oversight and taking full responsibility for the care of that child at the time needs to sign the document.

Regarding guardian reports on current status and updates on interval homework/practice

Q7. If the client is transported by the company van or school bus, is it appropriate to document that no caregiver report was obtained due to the client arriving by school bus/transport van?

A. No, it is important to document what happened during the interval since last seen by the provider. A note from the parent identifying any new interaction that resulted in a positive/negative behavioral change would be an example.

Regarding back-to-back sessions due to the 2.5-hour limit on CPT codes

Q8. If a technician completes consecutive sessions, who should sign the first note? Should the technician sign their own note since they remain with the client or do both notes need to be signed by the caregiver/guardian to indicate all notes were reviewed?

A. Each direct service provider (BT/RBT) must sign their own progress notes, even when providing consecutive sessions. While it is certainly good practice in coordinating care and informing parent/caregivers of clinical progress, it is not a requirement that they sign each progress note. A note stating when treatment was reviewed with a parent/caregiver, should be completed.

Q9. I cannot find the most recent copy of *Autism Services: Billing Guidelines and Procedure Codes*. The website tells me it has moved to a new spot at authorizations.bcbsm.com but that website does not work.

A. The document is located under the *Autism* section of **authorizations.bcbsm.com** in the *Resources* section.

Q10. Can you tell me if billing practices also need to change? Currently, if a patient was here for an eight-hour day:

RBT A Had them from 8-10 — 8 units
SLP from 10-11
RBT B had them from 11-1 — 8 units
RBT C had them from 1-4 — 12 units
Today, we would bill 420 minutes/28 units of *97153

A. Correct. If ABA is taking place the entire RBT time, by CPT code *97153 definition. Also, keep in mind that autism service codes do not include significant break times including things like indoor-outdoor recreational play, meals, naps, etc. that are not billable via the treatment codes (*97XXX). Unless these activities are part of a documented individualized treatment plan and require therapeutic intervention, they are not covered as billable services.

Q11. With these new guidelines, we would separate notes for each RBT and also would need to separate notes from 1-4 p.m. in the example above. Would we also need to split out the billing into multiple line items? For example:

RBT A bills 120 minutes/8 units
RBT B bills 120 minutes/8 units
RBT C bills 120 minutes/8 units
RBT C also bills 60 minutes/4 units

A. No. Separate progress note documentation as described above, in your example. ABA total units can be bundled and billed for a total of 28 units for the day by the supervising LBA. Remember, documentation and billing are two separate issues.

Q12. It appears that if notes are split due to the new 10-unit limit, the second claim line for *97153 will automatically deny as a duplicate unless the system "clubs" the units into a single claim per date of service. We use BIPtrack for our EMR system. We just want to confirm that although our notes will be separate for each 10-unit limit, we can still club the units into a single claim per date of service to avoid a clinical editing appeal for reconsideration.

A. Yes, you are correct. The guidelines are about documentation and not the number of hours of ABA authorized by medical necessity by Blue Cross Behavioral Health. It is acceptable to "bundle" the units into a single line per date of service for billing purposes. Billing is done via the LBA who is contracted with Blue Cross, not the behavioral tech.

Q13. Billing systems (the practice management systems most ABA providers are using to bill out claims) usually combine all sessions with a given code and rendering provider into one billing line.

A. Correct.

Q14. So, when providers ensure that there is one note (one "session" in the practice management system) for every 2.5 hours of service, it will still generate one line for billing. You had said that session length is not supposed to be affected by this new rule, it is just that there needs to be a separate note after 10 units of a given code have been provided? I am wondering how we will demonstrate that we are in compliance with this rule given how billing systems work. If we were to submit multiple claims for *97153 for the same client, under the same rendering provider in a single day we would expect some of them to deny as duplicate. This could cause an administrative nightmare for providers and cause a significant cash flow concern.

A. Complete documentation should be a part of the medical record. Billing is a separate issue and can be placed into one billing line, which is billed by the contracted LBA and not behavioral techs. Different providers use different EMRs and billing systems.

Regarding compliance, you are always subject to ensuring that documentation and billing support one another, if audited.

Q15. Under your example of "locations" that need to be listed in session notes you include "living room." You then state that there should be a new note for each location. That suggests that "kitchen" or "playroom" are new locations and would require a new note. My clients are very active and typically move around a lot in a session. Within a one-hour session I would expect that we would move between rooms, following their interests and engaging in play-based interventions 10 or more times. That would suggest that "living room" may not be a very good example of what you are trying to get at here. If I am right, you want the note to clearly create a picture of the service that were provided and the context of those services. Can we achieve that same goal in the narrative by stating the context in which we addressed the goal?

A. Yes.

Q16. Your guidance under the multi-family caregiver training documentation seems to include guidance and verbiage that should instead be under guidance for group services (*97154 and *97158), which are in fact missing from your guidance. It is confusing to call multi-family caregiver training a "socialization" group. This statement also seems contradictory.

"Note: Other than the group member in whose chart the note is written, don't mention other patients in the socialization group by name. Record members in attendance and who are absent along with key reactions and interactions of group members."

We are clearly not to include a log of members in attendance in the session note in the client's medical record (just the number) and we are not to mention other patients there at all, so where are we to record the members in attendance and interactions? Are we expected to have a separate log of this in addition to the client specific medical session note? That would then not be part of the medical record but somewhere else in our system in case of an audit, and for the purposes of tracking the group as a whole. We really do need a "how to" for this. Perhaps you work with a provider who does this in a way that meets your requirements and they could do a training showing one way to meet these requirements.

A. Providers that do this successfully produce a “master” document and then an individual note outlining the key components of their response to the session.

Q17. I notice that you are calling *97155 supervision though the code descriptor is clear that this is not supervision at all but is protocol modification. As a discipline, we are really trying to explain to providers that supervision is not separately billable and should not be confused with protocol modification. One is oversight of the program, program implementation, and client progress the other is training and quality control of the staff.

A. *97155 is “protocol modification”. You are correct.

Q18. Is the guidance below asking us to include in our *97155 note any non-billable coordination of care activities that we have completed since the last billed *97155 session?

A. Yes.

Q19. What is "interval homework assignment" referring to here? Is this supposed to be in reference to caregiver training?

A. No. This addresses the need to document any behavioral interventions, assigned practice at home or identified goals for parents/caregivers to address in between treatment sessions with professionals.

Q20. I learn so much from these trainings and appreciate learning from Dr. Beecroft. I would like to request documentation training in the following areas:
a) Developmental/Behavioral Screening and Testing
b) Psychological/Neuropsychological Testing

A. We recommend further education for provider partners via Continuing Education Credits.

Q21. Thank you for sharing the presentation information and answering many of the questions from the webinar so quickly! Unfortunately, after the webinar and reading through your attached documentation, we have some additional questions and thoughts to share on the new 2.5-hour requirement for session documentation.

In the presentation, it was shared that an LBA is required to sign off on BT/RBT *91753 notes. Can you confirm that our understanding of this is correct in that LBAs are required to co-sign ABA all treatment notes completed for their learners? If that understanding is correct, can you please share when this expectation and requirement went into effect?

A. Yes, that is correct. An LBA is ultimately responsible for the work being done for the treatment of their patients.

The publication date for autism documentation was September 2025. The *Behavioral health medical records documentation requirements for autism treatment services* document is located under the *Autism* section of **authorizations.bcbsm.com** in the *Resources* section.

Q22. It is our understanding that sessions can continue in length for the prescribed amount, but that session notes can only reflect 2.5 hours of service.

A. Correct.

Therefore, a learner who has a six-hour total session length, with two technicians, would now have four different notes to reflect their day, rather than two comprehensive notes, that reflect accurately the entire length of the scheduled session.

The four notes described above should, in fact, comprehensively reflect the entirety of the total time that ABA took place.

Q23. This change has a significant impact for providers, staff, and ultimately the children receiving care. As a result, this administrative change creates several problems:

- **Significant increase in documentation time for direct care staff, who are already stretched thin.**
- **Higher risk of errors or inconsistencies due to unnecessary fragmentation of a single therapy session.**
- **Reduced focus on clinical care, as technicians will need to write multiple notes per shift instead of one accurate, comprehensive session note.**
- **The lack of research or clinical input supporting this decision is concerning, as in the webinar it was shared that this 10-unit limit was selected arbitrarily, and that any unit limit could have been selected, "but this is where it landed"**
- **Disruption to established workflows, that have functioned effectively for several years**
- **This change may violate federal and state mental health parity laws, including The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), codified at 29 U.S.C. § 1185a and 42 U.S.C. § 300gg-26 and The Michigan Mental Health Parity Act, MCL 500.3406ff et seq.**
  - **As this change does not reflect a standard practice in medical/surgical contexts for analogous outpatient services; imposes a nonclinical administrative burden that disrupts continuous care; creates significant barriers to access and reimbursement for medical services and as a result, this disincentives provider participation and reduces service availability to learners with autism and their families.**

A. This requirement is less restrictive than for other outpatient behavioral health therapists or medical professionals needing to document every unit of service per CPT code. We are allowing multiple units of service (10) to be documented under one note.

Q24. If our above understanding of the LBA co-signing *97153 notes is now a requirement. There is an additional administrative burden on clinical staff. Again, there is a lack of research, clinical input or rationale to explain this change.

A. The LBA is the supervising, contracted provider for Blue Cross/BCN who is billing on behalf of the services provided by a BT/RBT. Their signature signifies their awareness and supervision of the treatment taking place.

Q25. We are asking for you, Blue Cross/BCN, to:

a. Reevaluate the 10-unit cap for session note documentation

A. What's to prevent a provider from now asking for a five-hour (20 units) or eight-hour notes (32 units) which has occurred? What and how do providers accommodate for their EMR and "session" when a member cannot effectively participate uninterrupted the entire time? Providers have shared that they then document what has occurred based on the number of units that actually transpired, whether that is two or 10.

b. Allow for a higher threshold that reflects typical ABA session length and staffing structure

A. What is "typical"? Providers have reported sessions that range anywhere from two to eight hours of ABA sessions and have requested the ability to document their practice at these intervals.

c. Provide clear clinical rationale for this decision and engage with ABA professionals before enforcing such requirements.

A. These guidelines are designed for providers to document their practice for multiple units (10) of therapy to ensure that there is a continuous record of ABA taking place,

taking into account treatment, non-reimbursable breaks/lunch and handoffs between providers.

Q26. If our EMR (CentralReach®) is set up to collect data for the full duration of the scheduled session (e.g. a three-hour session with one singular RBT) to portray an accurate percentage or rate per total session, are we able to pull in the data for both of our documentation notes and have different narratives to indicate which data occurred during which session?

A. Yes.

Q27. Our analysts are wondering about documentation requirements when a direct therapy session is split due to the new duration limits, but the technician remains the same. In this scenario, can the supervisor complete one *97155 note that spans both parts of the session?

For example, if a client has a *97153 session from 2:30-5 p.m. and then 5-5:30 p.m. with the same provider throughout, can the supervisor write one *97155 note covering 4:30–5:30 p.m.? Or would two separate notes be required for 4:30–5 p.m. and 5–5:30 p.m.?

A. In this scenario, the notes would be split, as described. The *97153 claim/bill would be bundled for a total of three hours (12 units). The LBA completing the protocol modification (*97155) would document at the times that they completed this work and then bundle that bill for a total of one hour.

FYI: ABA treatment duration is not required to limit hours of treatment to 2.5 hours (10 units). It is only for the purposes of documentation. For example, if ABA took place for three consecutive hours (12 units), two progress notes would be required.

Q28. Scope of Practice Concerns with *97153 Documentation Requirements: Under the BACB's practice standards, Behavior Techs are trained to implement treatment programs designed by a BCBA/LBA and to collect and record data, but not to interpret data, diagnose, assess risk, perform clinical analysis, or make treatment decisions. Several of the documentation elements require clinical judgment or interpretation that is beyond a tech's competency and scope.

A. We agree. In our guidelines, we had to take into account the fact that both BTs as well as an LBA can and do provide ABA services. We would expect that each type of provider would document their progress notes within the scope of their practice based upon education and training. For clarity, we will add this into the guidelines.

As a general rule, the following should be adhered to in documentation:

RBTs are responsible to document:

- session timing
- individuals present
- treatment procedures delivered
- data collected per protocol
- observable, objective behavior

LBA/BCBA and/or medical providers:

- diagnostic conclusions
- clinical status review and impressions
- risk assessments
- interpretation of treatment outcomes
- modifications to treatment plans
- summaries of clinical progress

Q29. Does Blue Cross/BCN allow for any billed direct services by a BCaBA? For example, can a BCaBA do *97155 or caregiver training *97156?

A.

- No. The only individual that can bill Blue Cross/BCN directly are LBA/BCBAs. Those are the only professionally licensed and credentialed individuals that we contract with.
- *97155 (protocol modification) must be billed and provided by a fully licensed LBA/BCBA clinician.
- *97156 (parent/caregiver training) could be provided by a BCaBA but must be billed via the LBA/BCBA who is contracted with us. The LBA must be supervising and sign off on the documentation.

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