Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Behavioral Health Summit — Autism Documentation Guidelines

Q&A from Sept. 11, 2025, event

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

October 2025

In this document

This document contains answers to questions that were asked during the September 11, 2025, summit event.

ABA therapy session time length

"Due to the sessions being 15-minute intervals, each progress note is limited to two hours and thirty minutes (2:30) elapsed time duration and must be limited to a singular location that is identified in the note, such as one on one, a specialized setting or within a quiet room, or for in-home services in the living room, bedroom, outside in the yard. Time during breaks, napping, or other break activity is not a billable service."

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Q1. From reading this, I understand that an ABA therapy session can be no longer than 2 hours and 30 minutes. Is that accurate? I also understand that a non-billable break must be provided to the clients. If so, is there a minimum requirement on how long the break must be?

A. No, that is not accurate. The presentation focused on documentation guidelines, not treatment guidelines. We are not suggesting that ABA services be limited to 2 hours and 30 minutes; rather, we are indicating that ***documentation*** of ABA services should not cover a period of time ***longer*** than 2 hours and 30 minutes (10, 15-minute units). Documentation of ABA services should include a new note for each interval and separate notes delineating transitions to each service provided that day (ABA, PT/ST/OT, group, etc.). It is not acceptable to provide one progress note for an entire five-hour day which includes transitions between different interventions/services.

Q2. How does Blue Cross Blue Shield of Michigan expect this to be billed if a session is limited to 2 hours and 30 minutes? A claim cannot have multiple line items with the same CPT code, and if more than 2 hours and 30 minutes of *97153 are billed, I would expect this to generate a rejection. If an approved autism evaluation center, or AAEC, diagnostic provider recommends any more than 12.5 hours per week, an ABA provider will not be able to accommodate with services since any time more than that cannot be billed. Can you provide specific directions on how these claims will be processed?

A. Again, we are not suggesting that ABA sessions be limited to 2.5 hours. Please see the above response.

Q3. Could you please share references citing a specific limit of 2 hours and 30 minutes? In my own research, I have found that a greater number of ABA hours does result in greater gains relative to the core deficits of autism. Furthermore, there was no mention of a specific limit on the duration of a session.

A. Again, we are not suggesting that ABA sessions be limited to 2.5 hours. Please see the above response for clarification.

Q4. The 2 hours and 30 minutes limit would seem to contradict medical necessity. ABA sessions cannot be tailored to help ASD children adapt to a longer social routine and structured environment of school (e.g. typical public school half-day kindergarten is 3 to 3.5 hours). Additionally, setting a specific 2 hours and 30 minutes limit on sessions would most appropriately reflect a "single treatment methodology, procedure, or setting" since it encapsulates every Blue Cross/BCN ABA patient into the same 2 hour and 30 minutes sessions.

A. Again, we are not suggesting that ABA sessions be limited to 2.5 hours. Please see the responses above.

Q5. The 2 hours and 30 minutes limit raises the question of medical parity. Would a prescription medication be limited to a specific dosage across all patients regardless of their height, weight, severity of symptoms and other important individualized factors? In other words, would these ABA dosage limits also be applied by Blue Cross/BCN to mental health benefits and to medical/surgical benefits equally as defined in Mental Health Parity and Addiction Equity Act of 2008?

A. Again, we are not suggesting that ABA sessions be limited to 2.5 hours. Please see the responses above.

Operational definition of a break

Q6. Is there a remedy for service providers to care for clients during breaks without loss of service time/opportunity? Though a break may occur, behavior technicians cannot simply leave the client as this would pose a great ethical and moral error equivalent to patient abandonment. Like every working individual, it is reasonable to assume the technician would expect payment during this time? Parents cannot be relied upon to leave their jobs 5 days per week, twice per day, at 1+ hours to provide this coverage. If this were the case, would this expectation be consistent with Blue Cross/BCN's direction to their employees who have children with autism to leave work 5 days per week, twice per day, at 1+ hours per day to provide this coverage without risk to their employment? Further, if this were to be covered under the Family Medical Leave Act, what would be Blue Cross/BCN's expectation of these same employees when the FMLA benefit runs out and the employee no longer has FMLA protection?

A. Breaks are not reimbursable and should not be billed using autism services codes (*97XXX).

Many providers build in short breaks at transition times between services such as ABA, PT/ST, socialization group, etc.

Nap time, meals, recreational play outdoors, etc. are not billable unless part of an individualized treatment plan where intervention is required and taking place.

Blue Cross/BCN is not advocating that we require parents/guardians to be relied upon to provide coverage during a members' or an autism providers' employee meals and break times. It is simply not billable time when autism services, by CPT code definition, are not taking place.

Federal and state labor laws provide rules on how employers pay and provide breaks for their employees. The time a clinician is working and paid by their employer does not automatically mean that time is billable to an insurance company. Insurance will only pay for the direct treatment portion of that time based on medical necessity and authorized care.

Q7. Part of our kids' programming includes built-in five-minute breaks outside or in different play areas. However, even during these breaks we may be working on behavior plans (e.g. not aggressing toward peers, self-regulation, etc.), manding, communication goals, etc.

A. The focus on breaks was about making sure that there are age and developmentally appropriate breaks and transitions between ABA and other activities. If "breaks" are built into programming and programming/intervention is occurring during this time, that is acceptable. The timing/interval of documentation (2.5 hours/10 units ABA) is just that, documenting your practice. It does not mean that programming must end at 2.5 hours.

Q8. What is considered a break? Is it a duration of time without demands? Transitioning to a place where the child can run and get some energy out? Just switching up the scenery?

A. See the response above.

Q9. If a child is engaging in behaviors during the break, do we discontinue programming since it's been 2.5 hours? If a child requires prompts or programming to communicate during these breaks, should we not offer those since we shouldn't be billing?

A. See the response above.

Q10. Does a child going into SLP/OT/PT count as a break from ABA?

A. We'd consider it to be a break from ABA, but not a break from intervention/programming.

Q11. If a child does ABA from 9 to 10 a.m., OT from 10 to 11 a.m. and ABA from 11 a.m. to 1 p.m., is this OK?

A. Yes, this would be documented as ABA, (4 units, *97153) from 9 to 10 a.m. and ABA, (8 units, *97153) from 11 a.m. to 1 p.m. Again, documentation would occur every 2.5 hours. OT would be billable separately and not during ABA time.

The question here, again, would be how and when breaks are built into the day, clinically and developmentally.

Duration of the required break

Q12. How long do breaks have to be? Or can someone just start a new session immediately after 2.5 hours?

A. Breaks from sessions/interventions should not be confused with documentation. Taking breaks and/or working them into the session for short intervals is not tied to the 2.5-hour documentation interval.

Breaks/downtime is determined by clinical judgement and not at a required interval. It should be determined by the needs of the member.

Q13. Most reputable clinics do an average of three-hour sessions at a time. Is there any way you'd consider extending this to three hours instead of 2.5? The ABA therapists have a hard enough time remembering to even submit a session note on time. Having them stop 30 minutes before the end of session will create nightmares in scheduling, logistics and training for most clinics. Also, what happens if a child is engaging in behavior after 2.5 hours? Should we not assist or should we conduct therapy and not bill?

A. We shared that we are willing to take the three-hour documentation guideline under advisement. The documentation interval guideline came as a result of reviewing documentation where very long periods of time or even a whole day of practice took place with only one short note.

Of course, we would expect that if a child were engaging in behaviors at 2.5 hours that your team would intervene. The interval is about documentation of practice, not clinical intervention.

Logistics of the break

Q14. Who sits with the child during this time?

A. How a provider navigates breaks/down time for members or employees is up to them. Insurance coverage does not pay for non-billable time outside of the billing codes.

Q15. If we pay our therapists to sit with a child for a 30-minute break, this is a large expense for the company since its non-reimbursable time.

A. See the response above.

Q16. If we are 'babysitting' the child while in our clinic, this would likely make us a childcare provider and our licensing would have to change to be similar to a daycare. Our liability insurance only covers medical.

A. See the response above.

Q17. Is this a 2.5-hour therapy cap for a whole day? What's to stop a bad clinic from just doing a new session note every 2.5 hours but still not offering a child breaks?

A. No, there is no 2.5-hour cap for therapy. The 2.5-hour interval is only related to documentation frequency.

Breaks are determined by individualized needs which are age and developmentally determined.

Billing incorrectly for non-service time can lead to claim denials and put the provider at risk of being audited for non-compliance.

Q18. What does "must be limited to a singular location that is identified in the note, such as one-on-one, specialized setting, or within a quiet room, or for in-home services in the living room, bedroom outside in the yard" mean?

A. Refers to documenting "where" therapy and services are taking place and with whom. Notes must indicate that a child has transitioned from ABA to OT/PT/ST and back to ABA. It is not acceptable to document, for example, several hours of treatment in one note that has taken place with different providers, doing different activities, in different locations/settings. All notes must be signed by the treating provider.

Q19. I'm assuming that we would just be a "specialized setting" but a lot of times we follow our kiddos lead and they may go outside, inside, bathroom, etc. What if a child relocates from the bedroom to outside, is this permitted?

A. Yes.

Q20. The updates now state that we can bill *97151 for coordination of care; whereas, previously we've been told we cannot do this. What should we do?

A. For *97151, when completing an assessment, one should include establishing care coordination goals with family/caregivers, other professionals (medical, behavioral, PT/ST/OT, etc.). Code *97151 does not cover the actual care coordination itself.

CPT code *97153

Q21. The first part states, "These requirements apply to behavior technicians, behavior tutors, and licensed behavior analysts," but the final part states that session notes must contain, "Signature and credentials of the registered behavior technicians, or RBT, and supervising LBA." We've been assured a few times from Blue Cross/BCN that RBTs are not required. This may just be a typo. Should behavior technician be added as an option for signature?

A. RBT’s are not a requirement. However, many providers are employing staff and using RBT’s, behavior technicians and tutors as their defined staffing. A better statement would read “Signature and credentials of the RBT, behavior technician (tutor) and supervising LBA.”

Q22. There are some inconsistencies with the language regarding the behavior technicians. In some areas, they are listed as simply behavior technicians or tutors, and in others, they are specified to be RBTs. We have not been notified of any requirements for the RBT credential, and while my agency does require the RBT credential for all technicians, we have a six-month window for technicians to get credentialed. Can you please provide clarification on any potential RBT requirements?

A. There are currently no requirements for using RBT's. Some providers use and refer to their staff as RBTs, behavior technicians, and tutors. Therefore, we've included all those titles in our documentation.

2.5-hour time limit per session note

Q23. I am not sure which clinics received observations, but I can assure you that our clinic has never provided 8 hours straight of services without breaks or changes in environments. I would encourage visits and observations to my clinic, and others similar to my own, to be able to showcase our structures, and how we utilize a variety of service methods that incorporate naturalistic learning opportunities. Additionally, the structure of our clinic is a maximum of 3 hour sessions at a time. However, during this time, children are receiving a mix of individualized instruction in a discrete trial formats, naturalistic instruction, often in the form of play, and social opportunities with peers, while still in a 1:1 format. We do also provide group based services utilizing the 97154 code, and even more so for children we are preparing to transition into a less restrictive (i.e., school based) setting, which can also help break up 1:1 sessions and provide a change in environment for clients.

A. Based on this presentation, this sounds acceptable and appropriate.

Q24. When you say a session note is required after 2.5 hours, what is the expectation after 2.5 hours? For example we run three-hour sessions. Is the expectation then that we have a separate session note for the remaining 30 minutes of the session? Or is the expectation that there is a "break" for the child? Many of our clients also receive speech and occupational therapy services at our clinic, and so those three-hour sessions are already broken up. However, this is not the case for everyone. For those that do, would that suffice to meet your requirements?

A. Yes. The 2.5-hour interval only relates to the interval of time to document your practice. It does not mean that therapeutic sessions are limited to that amount of time or in total hours per day. Transitions from services (for example, from ABA to ST, back to ABA) should be documented by each provider to track transitions between activities throughout the day. Also, these activities should be documented by each treating provider and billed separately, not concurrently.

Q25. I wanted to also just point out a few barriers that may impact this requirement. First is related to data collection and mastery criteria for goals. As I know you are aware, our treatment plans have objective, measurable goals with requirements for high levels of data collection. While not every agency utilizes electronic data collection, I would imagine the majority of providers do. There are unfortunately limitations to electronic data and how it can track things like mastery and phase change progression. My example will be quite specific, but I hope it gets the point across that I am trying to make:

How does the 2.5-hour time limit affect electronic data collection? In our clinic, all the data collected in one, three-hour session is compiled, and the system will help analyze if a program is ready to be considered "mastered." If we are required to end our session after 2.5 hours, and then run an additional 30 minute session, that will skew the data. It will also not provide enough time to complete multiple goals throughout that time period.

A. The 2.5-hour interval relates to documentation and not the length of a session. If you are authorized and meet medical necessity requirements for a six-hour day, then it would be expected that you would adhere to that amount of treatment time. If a member is unable to tolerate a three-hour session and the session ends in two hours, how do you mange that in your electronic data collection platform and wouldn't that also skew the data? If treatment plans are individualized, how is it possible that every member is locked in to a three-hour session at a time?

Q26. If the expectation is that we provide additional non-billable breaks for clients, agencies will either take on significant and unaffordable costs to pay staff, or if employers choose to require employees to clock out during those breaks, we could run into even more staffing issues. Employees will not be able to afford losing that many hours throughout a week. Since providers cannot be licensed as childcare or educational settings, they would likely need parents or caregivers to come to clinics to sit with their children during those breaks. This is not feasible for the majority of families.

A. 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.

As an aside, some clinics employ “floater” techs that provide a resource for covering breaks and lunches, for example.

Q27. I also had some questions regarding the location of services being limited to one location per 2.5 hours. As a clinic-based operation, we have multiple rooms throughout our center. Is the expectation that we confine a child to one room for the duration of that 2.5 hours? And for in-home services, is the expectation that a child is confined to one room in their home?

A. In this case, no. The guideline speaks to documenting your practice, including where each service takes place and noting transitions between service types and locations. For example, it would not meet guidelines to include several hours of treatment services, including different types of services (ABA, ST, group socialization) taking place in different locations in one documented note.

Q28. I did not see anything in the updated document related to session note requirements for *97154. Should we expect something similar for that code?

A. We have taken the idea of a three-hour time interval under advisement related to documentation. This time interval is not related to how long a clinical treatment session lasts. However, there are providers who are documenting sessions at less and more time than even that interval. Our goal is to ensure that treatment services are documented at a reasonable interval, by type of service, and by the individual providing the service.

Q29. Under the progress towards treatment goals section, it also states that "results of interval homework or practice of prior intervention" should be included. I am unclear what this means since our services are not academic in nature. Could you provide some clarification on this as well?

A. This does not speak to academic "homework". 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.