DRAGEN ACADEMY · FREE LESSON · BCBAS, CLINIC OWNERS, BILLERS · 10 MINUTES

How to check your ABA billing before an auditor does.

What it is. An audit compares three things for every billed session: the **claim line**, the **session note**, and the **authorization**. Where they disagree, the payer takes the money back. The six checks below are those comparisons, and you can run them in a spreadsheet.

Why it matters. When the HHS Office of Inspector General pulled a hundred enrollee-months of Medicaid ABA claims in Indiana, every one had an improper or potentially improper line. Wisconsin and Colorado: also 100 of 100. Almost none of it was clinical. It was arithmetic and filing — which means it can be found first.

THE SIX CHECKS

What an auditor compares, and the red flag for each.

1. A NOTE FOR EVERY LINE

Every claim line has a session note with the **same date and same code**. Pull one month of claim lines; find each one's note. *Red flag:* a claim with no note, or a note written after the claim went out.

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2. UNITS MATCH MINUTES

Adaptive behavior codes (97153, 97155, 97156) bill in **15-minute units**. Units × 15 must be supported by the minutes in the note. *Write your payer's rounding rule at the top of your*

sheet — some use a minimum of 8 minutes per unit, some use midpoint rounding — and apply that one. *Red flag:* 4 units on a 47-minute note.

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3. CODE MATCHES WHO DID WHAT

97153 is a technician delivering treatment by protocol. **97155** is the BCBA (or other qualified professional) modifying the protocol, with or without the client present. **97156** is caregiver guidance. *Red flag:* 97155 on a note that only describes running programs; supervision billed as 97153.

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4. INSIDE THE AUTHORIZATION

Date of service falls within the auth period; the code was authorized; the running total of units per code stays at or under the units authorized. *Red flag:* a session the day after the auth ended; cumulative 97153 units over the total.

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5. CREDENTIAL AND ENROLLMENT ON THAT DATE

The rendering provider was enrolled with the payer **on the date of service**; the technician's certification was current; any required supervision ratio was met. *Red flag:* a certification that lapsed for two weeks while sessions kept billing.

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6. OVERLAPS AND IMPOSSIBILITIES

One provider billed to two clients at the same hour. One client with two overlapping sessions. Twelve hours in one day by one technician. The same person billing 97153 and 97155 for the same minutes. (Two *different* people billing 97153 and 97155 at the same time is allowed under the code guidance; one person is not.) *Red flag:* sort by provider, date and start time and look for the collisions.

DO IT IN A SPREADSHEET

How to do it yourself, by hand: one row per claim line.

Export the month. Columns: date of service, client ID (never the name — you do not need it and it keeps the sheet out of the PHI problem), provider, code, units, minutes from the note, auth ID, auth start, auth end, auth units for that code, start time, end time.

1. **Check 2:** a column for `units × 15 ≤ minutes` (or your payer's rule). Filter for FALSE.
2. **Check 4:** a column for `auth start ≤ date ≤ auth end`; a running total of units per auth ID and code compared to the authorized units. Filter for FALSE and for over.
3. **Check 6:** sort by provider, then date, then start time. Any row whose start is before the previous row's end is an overlap.
4. **Checks 1, 3 and 5** need eyes on the note and the roster. Sample every line for a new provider; sample a fixed share for the rest, and write down the share you used.

WORKED EXAMPLE

Northside ABA, one month.

Made-up example. The names and numbers below are invented to show the method. No real practice, client or claim is described.

412 claim lines in September.

CHECK	LINES FLAGGED	WHAT IT WAS
2. Units vs minutes	19	Notes of 50–53 minutes billed at 4 units under a payer that rounds at the midpoint; 3 units was correct
4. Inside the auth	6	One client's auth ended on the 18th; sessions on the 19th, 22nd, 24th and 26th billed against it, plus two more after a renewal that had not posted

6. Overlaps	2	One technician on two clients at 3:00 p.m. on two Tuesdays — a scheduling copy-paste
1, 3, 5	0	Sampled 60 lines; clean

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27 lines out of 412. Every one was fixable before the claim went out. Found afterward, every one is a refund and a line in an audit report. The difference between the two is whether anyone ran the six checks.

MISTAKES TO AVOID

How self-audits fool the practice.

- Putting client names in the spreadsheet. IDs do the job and keep the file out of the PHI problem.
- Trusting the practice-management system’s unit count. It counted what was entered, not what was documented.
- Sampling ten lines, finding nothing, and calling the month clean.
- Checking one month and stopping. Auditors pull years.
- Emailing the spreadsheet around. Keep it where the notes are kept.

TRY IT

One question, then the answer.

A session note says 52 minutes. The claim says 4 units of 97153. The payer’s rule is that a unit needs at least 8 minutes past the last full unit. Is the claim right?

▼ Show the answer, and why

No — it is 3 units. 52 minutes is three full 15-minute units (45) plus 7 minutes, and 7 is less than 8, so no fourth unit. At 53 minutes it would have been 4. This is check 2, and it is the single most common line an auditor finds.

SOMETHING TO KEEP

Six-check worksheet.

DRAGEN ACADEMY · SIX-CHECK WORKSHEET · DRAGEN.CLOUD

MONTH:	PAYER AND ROUNDING RULE:	LINES IN EXPORT:

CHECK	WHAT I COMPARED	LINES CHECKED	LINES FLAGGED	FIXED / REFUNDED / DISPUTED	PAYER RULE CITED
1. Note for every line					
2. Units match minutes					
3. Code matches who did what					
4. Inside the authorization					
5. Credential and enrollment on the date					

6. Overlaps and impossibilities					

WHERE DRAGEN HELPS

The six checks, run on your export.

DRAGENaudit runs exactly these six comparisons on your billing export, on your own computer. There is no AI in it: it is arithmetic, and every flag can be checked by hand against this page. It identifies discrepancies for your review; whether any payment was improper is a decision for the practice, its counsel and its payer.

SOURCE

Where this comes from.

HHS Office of Inspector General, Medicaid ABA audit reports for Indiana, Wisconsin, Colorado and Maine (published results; ABA remains on the OIG active work plan). The adaptive behavior CPT codes (97151–97158) are set by the American Medical Association, effective 2019. Rounding and supervision rules are in *your* payer's provider manual — that document beats this page.

Examples on this page are made up. They contain no client, student or family information. This lesson teaches a method; it does not replace your child's care team, your BCBA, or your payer's written rules.

