PLUTUSHEALTH

Excellence in ABA Billing

2024 ABA Billing Guide

CHALLENGES, SOLUTIONS, AND BEST PRACTICES

Mastering ABA billing means staying current with changing guidelines. This comprehensive article provides the latest ABA billing updates. Learn from billing experts about common challenges, solutions, and best practices for every stage of ABA billing.

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HOW TO BILL INSURANCE FOR ABA THERAPY

Billing insurance for ABA therapy involves several steps before and after providing the service. Key steps include confirming eligibility and prior-authorization and then using the right codes and modifiers on the claim. It's important to keep track of the different payer and state requirements.

Dawn Price is the director of revenue cycle management at Little Spurs Autism Centers and Little Spurs Pediatric Urgent Care

"ABA therapy is a relatively new field that presents unique challenges when it comes to billing," says Dawn Price, director of revenue cycle management at Little Spurs Autism Centers and Little Spurs Pediatric Urgent Care. With 20 years of experience in RCM and clinic operations, Price is adept at negotiating competitive rates with payers, credentialing, implementing systems and process improvements, maximizing reimbursements, and managing diverse teams.

Price says the ABA billing process reflects ABA therapy's unique nature and the clients' particular needs.

"In ABA, clients usually need prolonged, consistent care, an uncommon situation in most medical fields," Price says. "Also, whereas some kiddos may only need a few hours of therapy a week, others need therapy full-time. As a result, insurance payers usually approach ABA on a case-by-case basis and almost always require pre-authorization before covering any treatment."

Rajgopal HK, Associate Director at Plutus Health Inc., says that ABA billing is complex because there are no uniform guidelines or rules. He says the lack of standardization may relate to the fact that Medicare is primarily for people over 65 and doesn't cover ABA therapy.

Rajgopal HK, associate director at Plutus Health Inc

"Medicare is often one of the first payers to offer new therapies like ABA," Rajgopal says. "In many cases, private payers look to Medicare to set guidelines. However, because ABA therapy primarily serves children rather than older individuals, Medicare never established this standard. Consequently, many private practices made their own guidelines, creating multiple-payer requirements rather than a unified system. This diversity in payer and state guidelines can be very challenging to manage."

Price provides this broad overview of how the ABA billing claims process works:

“A parent will call us and ask us to evaluate their child for ABA therapy,” she says. “After we gather their basic information, the front-end staff will schedule an appointment at least a few days out so we have a few days to confirm their eligibility or give them other options to pay for care.”

Price says the parent's only task should be calling to make the appointment.

“The clinic should do the heavy lifting of figuring out whether and how the parents’ insurance covers ABA therapy,” she says. “The front office will contact the parent’s insurance company to see if ABA therapy is a benefit and determine whether we need to make a pre-authorization request. Then, we’ll call the parents back and let them know what we found out from their insurance company, give them a quote of benefits, and start working on what a reasonable treatment plan is for them.”

After the appointment, the provider will submit a claim based on the parents' specific payer requirements.

“Every insurance company has their own ABA billing guidelines that we have to follow regarding CPT codes, modifiers, and how they categorize RBTs and BCBAs,” Price says. “There are also specifics regarding prior-authorization, the number of session hours we can bill, and more. It’s a very complex and unique process that requires an expert ABA billing team dedicated to the task.”

Key Takeaways:

- **Insurance payers do not follow a uniform ABA billing process, so pre-authorization is key.**
- **Tracking and managing authorized therapy hours for each patient can present challenges.**
- **ABA CPT codes are generally straightforward, but selecting the correct modifier can be challenging because it changes based on the state, payer, and provider credentials.**
- **Practice management software automates tasks such as verifying authorization hours, assigning CPT codes, and flagging problematic claims.**
- **Experts recommend integrating ABA billing into a comprehensive revenue cycle management process and outsourcing RCM to an experienced ABA team.**

STEPS IN THE ABA BILLING CYCLE

The ABA billing cycle begins before the service. The front-end staff checks client eligibility, provider credential requirements of the payer, and pre-authorization. During the service, providers carefully document the session. Then, the billing team sends claims according to each payer's requirements and follows up on any denials.

Here's a summary of the steps in the ABA billing cycle:

★ Eligibility & Benefits Verification and Prior-Authorization

The ABA billing process starts as soon as a parent makes an appointment. "The billing cycle begins when a child's family requests service from a clinic," Rajgopal says. "Before the appointment, the front-end staff checks whether the patient's insurance covers an initial assessment. Then, they contact the family to tell them what they learned." Rajgopal notes that the initial evaluation will help determine how many hours of therapy the child may need. "After the first few sessions, the BCBA will determine the appropriate continuation of treatment, like the frequency and duration of ABA therapy."

After the assessment, the provider will submit documentation outlining the treatment plan to the insurance company. The plan will include the therapy goals and the expected duration and frequency of ABA sessions. Then, it's up to the company to accept or reject that authorization for the recommended ABA treatment. If the insurance company authorizes the service, it's for specific "units of service," where one unit is usually 15 minutes of therapy. The authorization usually lasts for six months. If the provider wants to continue the therapy after six months, they'll have to submit more documentation to renew the authorization.

★ Pre-billing & claim generation

After a provider, like a BCBA, renders a service, the billing team at the clinic will submit a claim to the insurance payer.

Balaji (Bala) Ramani, vice president of business development at Plutus Health, says that a BCBA or RBT will take thorough session notes that will help the billing team create a claim. Bala is a senior management sales professional with several years of experience in building successful marketing and sales teams.

Balaji (Bala) Ramani, vice president of business development at Plutus Health Inc.

"In an ideal world, the provider is writing detailed session notes using a template that includes categories for every type of information the payer needs," he says. "For example, they should write the start and end time of the session and describe their basic interventions, among other important details."

After a provider finishes their session notes, the billing team generates an insurance claim for the session.

Here's a summary of the most important parts of a claim that the billing team verifies before submitting it to the relevant insurance payer:

Authorization and units

The pre-billing team makes sure that the child is still within the amount of units the insurance team authorized. If they find that the provider used more units than the authorization allows, the pre-billing team discusses the claim with the provider and adjusts the units before submitting the claim.

Modifiers and CPT codes

Each claim must include a Current Procedural Terminology (CPT) code and modifier to describe the specific service and the credentials of the rendering provider.

The pre-billing team will double-check that the CPT code and modifier are correct based on the payer's requirements and the provider's session notes.

Provider credentials

Some insurance providers allow BCBAs to perform only certain services. The pre-billing team will ensure that the provider credentials align with the level of service and the payer's requirements.

Specific payer session note requirements

Session note requirements change by the payer. The pre-billing team will double-check that the session notes meet the specific payer's needs.

Submitting session notes as part of a claim is usually not mandatory. However, many ABA experts recommend that clinics maintain thorough and complete records because payers often require session notes during claim audits.

★ Claim submission, clearinghouse, and insurance processing

After the pre-billing team prepares the claim, they submit it to the insurance company.

Bala describes the next step:

"After validating each claim during the pre-billing process, the biller will submit the claim to the payer. First, it goes to the clearinghouse linked to the billing system, where the clearinghouse has its own set of scrubbers, and it checks the claim for any blatant errors. If the clearinghouse approves the claim, they send it to the payer."

After the payer receives the claim, they run it through their system to check for errors. At this point, the payer will either send a payment or a denial.

★ Denial management & reconciliation

“The industry standard is to achieve a 95% or greater acceptance rate, meaning 5% or less of your claims turn into denials,” says Bala. “But even the best teams will receive a denial — no one has a 100% acceptance rate. At that stage, it’s up to your RCM team to go through a denial management process to try to reconcile the funds.”

Denial management involves reviewing denied claims to identify easily correctable issues. For example, a denial management team can identify common problems like misspelled names or incorrect CPT codes and resubmit the claim. Denial management also means establishing processes to avoid submitting bad claims, like using software to flag eligibility and authorization issues before submitting the claim.

HOW TO BILL INSURANCE AS A BCBA VS. AN RBT

BCBAs and RBTs may have to use different modifiers based on the type of the services and the payer's specific requirements. Certain payers do not separate RBT and BCBA services. Instead, they include RBT services as part of their supervising BCBA's claim.

The difference between billing insurance as an RBT or a BCBA depends entirely on the payer.

"Every insurance company has its own guidelines that we must follow," Price says. "Most insurance companies only accept claims for services rendered by a BCBA or an RBT with supervision from a BCBA. In both cases, we will submit a claim for the BCBA, with any RBT services lumped into that claim."

However, Price also notes that certain payers, like Tricare, do accept and require RBT services to be billed separately. In those cases, you must adjust the modifier codes to communicate that you are billing exclusively for RBTs services.

ABA CPT CODES

ABA CPT codes are a set of standardized terms that describe specific ABA services and treatments. As of 2024, there are 10 CPT codes that describe patient assessment tasks, treatments, and interventions. Providers enter CPT codes on insurance claims.

The American Medical Association (AMA) uses CPT codes to create a uniform language for providers to describe medical treatments and services. The purpose of CPT codes is to streamline insurance claims and quickly communicate basic services to different stakeholders.

The two code categories are CPT I codes and CPT III codes. CPT I codes describe routine services, and CPT III codes describe new and emerging technology.

Bala says that the process of selecting ABA CPT Codes is straightforward.

> **"There are only 10 CPT Codes in ABA," he says. "Other medical specialties, like cardiology or surgery, have hundreds of codes that the provider must select from. One misplaced number might completely change the code's meaning and lead to a denial. Luckily, the low number of CPT codes means it's relatively easy to avoid this issue in ABA."**

Here's a brief overview of ABA CPT codes as of 2024 from the ABA Coding Coalition. All payers, including Medicaid, use these CPT codes.

Adaptive Behavior Assessment Codes:

These codes describe observational behavior assessments on a new or existing patient. The definitions of each code come verbatim from the AMA.

★ Category I codes:

- **97151**

  "Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan."

- **97152**

  "Behavior identification supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes."

★ Category III codes:

- **0362T**

  “Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administered by the physician or other qualified health care professional who is on site, with the assistance of two or more technicians, for a patient who exhibits destructive behavior, completed in an environment that is customized to the patient's behavior.”

Adaptive Behavior Assessment Codes:

These codes describe services related to rendering ABA treatments to address any behavior issues or gaps that an ABA assessment found.

★ Category I codes:

- **97153**

  "Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan."

- **97154**

  "Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes"

- **97155**

  "Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes."

- **97156**

  "Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes."

- **97157**

  "Multiple-family group adaptive behavior treatment guidance, administered by a physician or other qualified healthcare professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, every 15 minutes."

- **97158**

  "Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional face-to-face with multiple patients, each 15 minutes."

★ **Category III codes:**

- **0373T**

  “Adaptive behavior treatment with protocol modification, each 15 minutes of technicians’ time face-to-face with a patient, requiring the following components: administered by the physician or other qualified health care professional who is on site, with the assistance of two or more technicians, for a patient who exhibits destructive behavior, completed in an environment that is customized to the patient’s behavior.”

ABA BILLING MODIFIERS

ABA billing modifiers describe the provider’s credentials and are critical for insurance claims. ABA modifiers can be complex because each payer and state has unique requirements. Some payers also use modifiers to indicate who was present at the session.

In ABA, the modifiers usually reflect an RBT, a BCBA, or a BCBA-D.

“Although CPT coding in ABA is simple, adding in the right modifier can be tricky,” Bala says.

“That’s because each payer and each state have specific ways to use a modifier.”

Modifiers vary by state, payer, type of service, and provider credentials.

"For instance," Bala says, "the modifier in Washington state will differ from that in California, even if the service and provider credentials are identical. Additionally, the session's location and the specific individuals present during the session also influence the modifier."

Here's a summary of the four most common ABA billing modifiers. Note that different payers have different modifier requirements, and this list is not exhaustive.

- **HO modifier**: he HO modifier denotes that an ABA supervisor, like a BCBA, rendered the services that the CPT code indicates.
- **HN modifier:** The HN modifier describes that a trained provider with a bachelor's degree and a BCBA, rendered the services.
- **HP modifier:** The HP modifier describes a doctoral-level provider, like a BCBA-D.
- **HM modifier:** The HM modifier denotes behavior technicians or anyone without a bachelor's degree.

ABA BILLING GUIDELINES AND BEST PRACTICES

ABA billing best practices include establishing a strong front-end and pre-billing process. Experts also strongly recommend investing in practice management software to automate tedious tasks. Other guidelines include hiring experts who know your state and payer guidelines.

Here's a list of ABA billing guidelines and best practices from RCM and ABA billing experts:

★ Establish a solid front-end process

Rajgopal emphasizes maintaining accurate patient information to prevent eligibility lapses and billing delays.

"Make sure your eligibility verification process is on point," he says. "Sometimes, patients experience life changes that affect their insurance coverage, yet fail to inform their ABA therapy provider. They might move, get divorced, or change their insurance provider. Front-end staff should always confirm patient demographics and insurance details to avoid eligibility issues and streamline payment processing."

Bala and other experts also stress the importance of collecting payment methods and insurance IDs upfront and confirming basic patient information, like phone number and address, at each appointment.

★ Hire ABA billing specialists

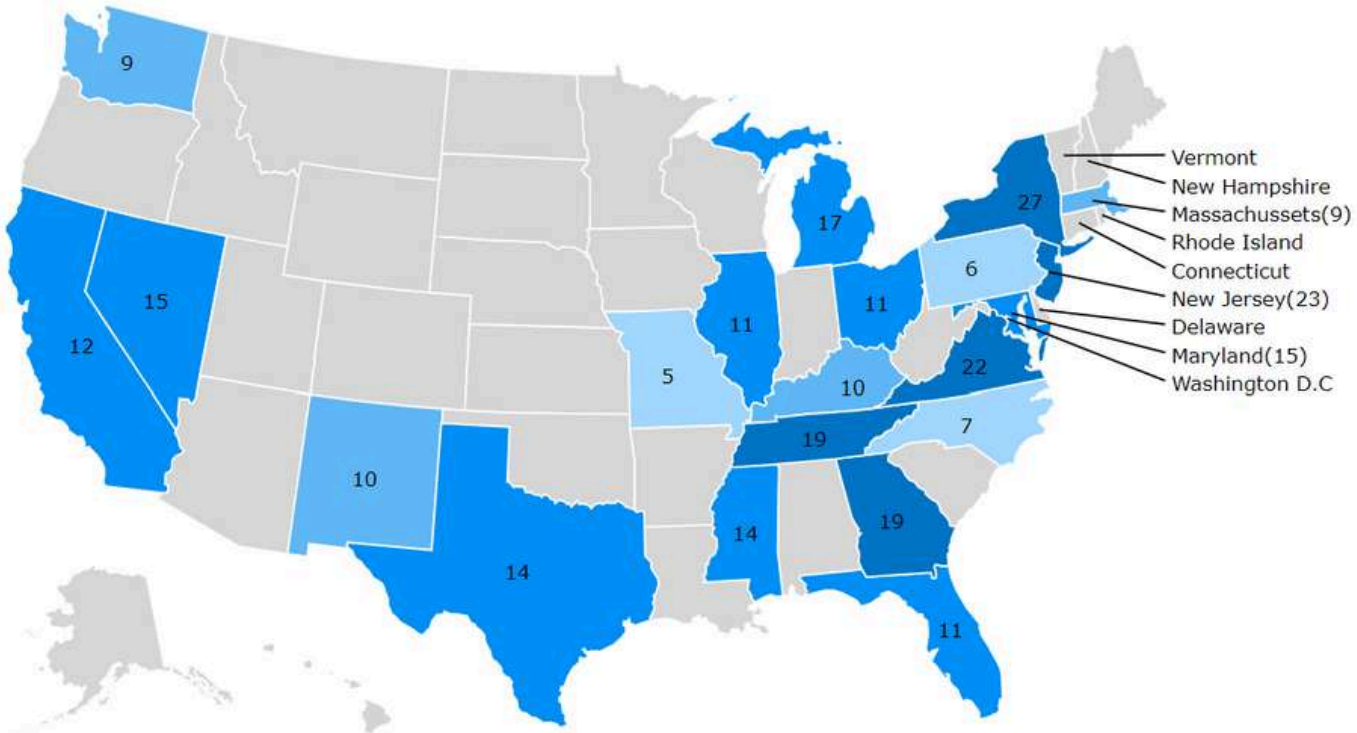
Price underscores the importance of hiring specialists in ABA billing. "Not every medical billing expert understands the complexities of ABA billing," she says. "I strongly recommend that ABA clinics invest in a biller who has experience in ABA and has the expertise to give each account the specialized attention it needs."

★ Stay proactive

Price says that staying informed about industry updates is critical, especially since ABA billing doesn't have a uniform system and is subject to many payer and state-specific changes. To stay current with billing guidelines, use the Plutus Health ABA Billing Checklist by State & Provider.

PLUTUSHEALTH
Excellence in ABA Billing

Comprehensive ABA Billing Checklist for Providers by State



Select the State:

California

Select the Payor:

Managed Health

California
State selected

12
No of Payors

Checklist	Mandatory Fields (Y/N)
Patient Full Name	YES
Patient DOB	YES
Rendering Provider Full name	YES
Rendering Provider Credential (BCBA/RBT/BCaBA)	YES
Rendering Provider Signature (BCBA/RBT)	YES
Supervising Provider Name and Signature (If Rendering provider RBT)	YES
Signature Date and Time	YES
Service Location (POS)	YES
Session Date and Time	YES
CPT and Diagnosis code should present on Medical records	YES
Detail description of service performed	YES
Treatment plan if required (Indicates Duration of service) or Progress Notes	YES
Should Supervising provider be present at the time of service	YES
Patient/Subscriber Signature required or Not	NO
Do we have any separate guidelines to be followed for the plans HMO, PPO and POS	Follows - CMS Guidelines
Additional Information	NO
Was there any change in Modifiers usage or in guidelines- HO, HM, HN, GT, 95	NO
Insurance Phone #	18444-966-0298

Download Checklist

Disclaimer: The information contained in these checklists was last revised on May 2024. Users are advised to verify the current billing guidelines directly with their respective insurance providers, as policies are subject to change without notice.

"Stay engaged with your network of ABA professionals and payer representatives to anticipate and prepare for changes proactively."

Verify authorization units before billing the claim

Bala explains that overdrawing authorization units will cause payers to deny your claim. However, leaving unused units on the table may reduce the number of units the payer allocates during the next authorization period. "If they gave you 100 hours, and you only use 80, there's no incentive for them to renew 100 hours again if they see that you don't need it."

Price recommends that clinic owners automate the task of tracking service units. "Invest in billing software that can keep track of how many session hours each patient has left. For example, some software flags accounts that are approaching their unit limits."

Check session notes

Many payers have common session note requirements, but they're rarely identical

"We recommend our clients use a session note template for each payer," Rajgopal says. "This means that the provider will always be recording the information the specific payroll asks for. The template design will prompt them to do so, with pre-defined categories for each requirement, like a section for the session length or a drop-down menu that prompts the provider to select from a list of treatments."

Other ABA session note tips include always having a BCBA approve session notes and creating payer-specific note templates.

Guide parents toward resources

"Parents often feel isolated and confused by the overwhelming insurance process," says Price. "As RCM experts, our role is to reassure them that we'll handle the paperwork. All they need to do is reach out to us."

She adds: "We're committed to guiding them through the process and finding a solution for their child's needs. If parents feel isolated and confused, they might hesitate to pursue ABA therapy, even if their insurance covers it."

Price also suggests that clinics and billers can connect parents with local ABA groups.

"Parents and children aren't alone — there's likely a supportive local network facing similar challenges."

Invest in practice management software and outsource your RCM

"Having a specific practice management software to build in your specific payment schedules points the provider to the correct codes to be used in every situation," Price says. "The system handles a lot of the tedious tasks for you and creates a streamlined process and faster turnaround times."

The software ends up benefiting everyone. "This software doesn't just improve your bottom line," Price says, "it helps parents and your patients by reducing the risk that paying the claim will fall on their shoulders."

CHALLENGES OF ABA BILLING

The major challenge of ABA billing is the lack of standardization. Different payers and states have different requirements, which complicates claim submission. Also, authorizations and credentials are key but require time and effort.

Here's a list of the major challenges of ABA billing:

Diverse payer and state requirements

Keeping up with changing state and payer requirements presents the biggest hurdle in ABA billing. Unlike many medical fields, few uniform rules or mandates govern ABA billing.

Rajgopal explains how this situation started.

“In the beginning, not every state agreed that there was a need for ABA,” he says. “Strong outreach and advocacy efforts began to change the paradigm. Eventually, each state passed legislation that gradually led to coverage for ABA services.”

However, this state-by-state approach created state-by-state requirements, even under Medicaid.

“Of course, private insurance companies also dragged their feet and have adopted their own standards,” Rajgopal says. “As a result, there’s no universal standard in ABA billing—you must stay on top of the evolving and different requirements that change not only based on which state but based on your provider's credentials as well."

Pre-authorizations

Pre-authorizations refer to approvals granted by insurance companies or healthcare payers for providers to perform medical services for a specific patient. Obtaining authorization involves a review to determine the necessity of the services.

Pre-authorizations play a large role in ABA billing because most patients need long-term, consistent access to ABA therapy.

Bala explains the two main reasons that authorizations are so important in ABA.

"First, unlike many medical specialties, patients with ASD (Autism Spectrum Disorder) need ABA therapy for a very long time, on a consistent, repetitive basis, much more often than a yearly physical or a cardiology screening, for example."

The second reason is the variability of ASD.

"ASD doesn't present in the same way all the time, of course,” Bala explains. “Some kids just need help developing social skills. Others can't pick up objects or are even capable of inflicting self-harm. There's a huge range of presentation and severity that really dictates how frequently and how intense the service must be.”

As a result of these unique aspects of ASD, insurance payers require prior authorization to know exactly where the specific patient fits on the ASD spectrum, how much treatment they need, and how often they need it.

Here are other challenges related to authorizations:

- **The time and resources required**

"Payers typically grant a certain level of authorization for six months," explains Price. "However, six months of treatment is usually insufficient. That means that the clinic must submit a request for re-authorization that demonstrates both the effectiveness of the current care and the patient's ongoing need for treatment. Substantiating these points demands that the ABA therapist take extensive notes and collect robust data."

- **Can be difficult to track units**

ABA clinics must closely monitor how many hours of therapy each payer allows for each client.

"Authorization drives everything in ABA. A miscalculation could result in a financial loss for the clinic or a loss of therapy hours for the patient," says Rajgopal.

"If you exceed your units, the payer will deny your claim. Simultaneously, if you fall short of your units, the payer will reduce your authorized units for the next period. In other words, they will cover fewer hours of therapy for the client."

- **Clinics perceive authorization as difficult to outsource**

Most clinic owners are reluctant to entrust the authorization process to external RCM experts, even though authorization poses challenges in ABA billing. Rajgopal explains: " During the authorization period, insurance companies often request 'peer-to-peer' reviews, where a qualified practitioner that works for the payer discusses authorization with a qualified practitioner from the clinic's end. Therefore, ABA clinics would only consider outsourcing to a partner if they are confident that the partner also has a team member with the necessary clinical expertise to represent the clinic effectively."

High demand for ABA can rush credentialing:

Credentialing poses significant challenges in ABA billing due to the high demand for ABA therapists. Some clinics rush therapists to deliver a service before they obtain the necessary credentials, which results in a denial since Credentialing cannot be rushed and takes its own timeline with the Payers.

Additionally, therapists may be credentialed with one insurance company but not with another. As a result, the billing and front-end staff must ensure that any therapist providing services has credentials with the client's insurance company.

Benefits verification

Verifying whether the client's parents' insurance covers ABA therapy can pose challenges.

"Assessing eligibility and benefits requires expertise, as ABA is not as common as other mental health services, and the specific language around ABA services, especially from insurance payers, can be difficult to understand," Bala says. "Additionally, since most children rely on their parents' insurance, the billing team must understand how the parent's insurance extends to cover their children."

Duplicate billing

Duplicate billing occurs when a therapist mistakenly records the same session information twice and then submits separate claims for each entry. Price says that duplicate billing is a common billing challenge in ABA therapy. "Due to the fast-paced nature of their work and the administrative tasks of submitting a claim, the provider may accidentally duplicate session information when completing billing paperwork or electronic claims submissions."

UNDERSTANDING REVENUE CYCLE MANAGEMENT FOR ABA THERAPY

Revenue cycle management (RCM) in ABA is the process of managing your clinic's entire finances. Optimizing RCM improves your cash flow and the patient experience. Experts recommend outsourcing RCM to a trusted expert.

Revenue cycle management (RCM) involves managing all aspects of a clinic's operations to optimize its finances, from patient intake to ABA billing tasks like submitting claims and denial management. Experts stress that the different steps in RCM all affect the process as a whole.

Mark Phan, senior manager at Plutus Health Inc.

"ABA billing is just one component within a clinic's broader RCM framework," says Mark Phan, a senior client success manager at Plutus Health Inc. with nearly a decade of experience in RCM and ABA. "Unfortunately, many billers approach ABA billing without considering its place in the larger RCM cycle."

Mark says it's critical to outsource your billing to an expert team that will manage your RCM end-to-end. He says that the best vendors don't just want to reduce your denials; they want to help you grow your clinic

"It's not just about partnering with someone who can help you keep the lights on," he says. "Look for a partner capable of driving business expansion. For example, the best vendors will strategically use key performance indicators (KPIs) and other tools to forecast revenue changes. They will also understand how to make meaningful adjustments to increase revenue and facilitate long-term growth."

Here are two examples of how ABA clinics grew their businesses and reduced their denials by partnering with an RCM expert.

★ ABA clinic significantly reduces denials and increases revenue

Faced with significant RCM challenges, an ABA clinic partnered with Plutus Health to optimize the RCM processes, reduce denials, and enhance cash flow. The results included a 42% reduction in denials, a 23% increase in cash flow, and a 33% decrease in the number of accounts in A/R for over 90 days.

To achieve these results, Plutus analyzed the practice's RCM strategy and identified the major source of denials from their major payers, mostly due to coding(modifier) errors. These denied claims led to many accounts staying in A/R for a long time, reducing cash flow and revenue. In response, Plutus cleaned up the practice's modifier and coding system, trained the client in their software, and improved the pre-authorization process.

★ Large ABA clinic partners with Plutus Health to improve RCM

A large ABA practice approached Plutus Health to improve its RCM in preparation for expanding its ABA services nationwide. With Plutus' help, the clinic successfully reduced its denial rate to less than 5% and streamlined its RCM in preparation for a nationwide expansion.

Plutus Health's analysis revealed that improper credentialing was the root cause of most of the clinic's denials. Additionally, they identified that payers incorrectly denied many claims, resulting in lost revenue for the clinic. Leveraging advanced software and analytical tools, Plutus Health identified other potential gaps in the RCM process. They developed an approach to flag problematic claims and implemented a robust process to reduce denials and reconcile money from claims that payers had denied incorrectly.

HOW TO STREAMLINE YOUR ABA BILLING

Streamline your ABA billing by teaming up with the RCM experts at Plutus Health. Recognized for top-tier outcomes, Plutus uses cutting-edge analytics for personalized solutions. Our ABA experts and certified coders stay updated on changing requirements, codes, and more, ensuring your cash flow and patient services never falter due to evolving payer demands.

In addition to billing, Plutus' end-to-end RCM services cover every aspect of your workflow, from front-end check-in to denials management. Plutus' ABA practice management software is provider-friendly and features customizable data collection tools, session note templates, and more.

Join the list of ABA clinics and BCBAs that have transformed their billing processes with Plutus Health's Innovative RCM solutions. With Plutus, you'll experience the ease of transformation that empowers your ABA practice to reach its fullest potential.

Schedule an ABA Expert Call