Molina ABA Weekly Approved Units Policy
Provider Guide & FAQs

Background

Beginning August 1, 2026, Molina Healthcare of Washington Medicaid is transitioning to a weekly approved unit structure for Applied Behavior Analysis (ABA) service reimbursement. ABA services will be authorized using a weekly approved unit limit rather than total units for the full authorization period.

This change streamlines claims, supports consistent service delivery, and reduces mid-authorization adjustments. No action is required for existing authorizations or claims submitted prior to July 31, 2026, including those with date ranges extending beyond this date.

This Q&A accompanies the ABA Weekly Approved Units Provider Notification and the ABA Weekly Units Payment Integrity Policy. Plans should reference both when customizing this guide.

Section outline

---

1. Effective date & applicability

Q: Does this only impact prior authorizations (Pas) received and approved after August 1, 2026 or does it also impact current PAs with an end date after August 1, 2026

A: Only new requests and authorizations determined after August 1, 2026, will be impacted. Existing authorizations, including those with date ranges extending August 1, 2026, are not affected.

Q: If a current PA is approved with an end DOS after August 1, 2026, will the weekly unit structure apply?

A: No. Existing authorizations are not impacted. The weekly structure applies only to new initial requests and new continuation-of-service requests submitted on or after August 1, 2026.

2. Authorization & claims process

Q: Will existing PAs be resent to providers with the weekly calculation?

A: No. Only new requests for initiation or continuation of services are impacted. Existing authorizations will not be reissued.

Q: How are weekly units determined?
A: Weekly approved units are based on the treatment schedule submitted as part of the prior authorization request and approved through medical necessity review. For example, a request for 20 hours per week of direct ABA services will be converted into the equivalent weekly authorized units based on the applicable billing codes and unit definitions. Final approved units may differ from requested units based on clinical review.

Q: How should providers calculate the weekly limit? Monday–Friday, Sunday–Saturday, etc.?
A: Providers should calculate the weekly limit on a Sunday- Saturday basis and continue to bill (submit claims) as expected by CPT and date of service with unites tied to that specific day/session. Providers do not need to change how they are billing.

Q: Is there a predetermined weekly unit limit?
A: No universal predetermined weekly limit. Weekly approved units are based on the hours the provider indicates on the authorization request. All decisions are based on medical necessity.

Q: Is there a daily limitation?
A: Molina follows applicable Washington Administrative Code (WAC) WAC 182 531A requirements governing ABA services. Current regulations do not establish a specific daily service-hour maximum.

Q: How will approved weekly units appear on authorization notifications?
A: Authorization notifications will display approved units using the new weekly authorization structure. Providers should review each authorization carefully and bill services consistent with the approved weekly amount.

3. Billing & reimbursement

Q: What happens if a claim exceeds approved weekly units?
A: Claims exceeding the weekly limit could be denied or adjusted. Billing more than approved frequency is subject to post-payment recovery. * See section 4.

If a member's clinical needs change and additional services are needed beyond the current approved weekly amount, providers should submit a new authorization request with updated clinical documentation supporting the requested increase before rendering services exceeding the approved authorization whenever possible.

Q: Can providers submit claims for multiple weeks on one claim?
A: Yes, as long as no single week exceeds the weekly authorized amount. Timely filing guidelines still apply.

Q: What CPT codes are affected?
A: 97153, 97154, 97155, 97158, and 0373T. All billed per 15-minute unit.

Q: Can unused units from one week be carried forward into another week?
A: No. Approved units are assigned to a specific authorization week and cannot be accumulated, banked, or carried over to future weeks.

4. Payment integrity & post-payment review

Q: What is the purpose of this policy change?
A: To support consistent service delivery, reduce mid-authorization adjustments, streamline claims, and identify utilization patterns that differ significantly from the treatment plan submitted and approved through the authorization process. Post-payment review targets utilization patterns, not one-off adjustments.

Our goal is to ensure members receive ongoing, regularly scheduled ABA services, as consistent intervention is necessary to support the acquisition, generalization, and maintenance of adaptive behaviors. Sporadic or intermittent treatment limits these outcomes.

Q: Scenario: Two children in a 2:1 model (97154), one cancels, remaining child shifts to 1:1 (97153). Will this be flagged?
A: No. This policy does not penalize one-off clinical adjustments. The review targets providers who consistently exhaust authorizations early due to regular overuse of weekly units. Isolated scheduling changes are expected clinical care.

Q: Can providers still request treatment plan addendums to move units between CPT codes?
A: Providers may adjust units across CPT codes as appropriate.

Providers may reschedule missed visits within the same authorization week when clinically appropriate. Any make-up services must remain within the member's approved weekly unit limit. If services cannot be completed during the affected week, providers should resume the approved treatment schedule in subsequent weeks.

Q: Will all claims exceeding weekly limits automatically be recouped?
A: Payment review findings are based on review of the authorization, claims history, and supporting documentation. Each review is evaluated individually and in accordance with applicable provider contractual and regulatory requirements.

5. What stays the same

Q: Does the medical necessity review or PA process change?
A: No. Medical necessity review and PA requirements remain the same.

Q: Do covered ABA CPT codes change?
A: No. The covered ABA CPT codes remain the same.

Q: Are existing authorizations or previously submitted claims affected?
A: No. No action required for existing authorizations, submitted claims, or authorizations crossing August 1, 2026.

6. Provider support & contacts

Q: What should providers do if they have questions?
A: Contact Denise Kohler Manager, Healthcare Services Denise.Kohler@MolinaHealthCare.com or Lynette Jordan, Director, Provider Networks Lynette.Jordan@MolinaHealthCare.com. You can also reach out to the Provider Relations team at MHW_Provider_Relations@MolinaHealthCare.Com.

Q: Where can providers find additional resources?
A: Refer to the Provider Notification distributed June 1, 2026, available on the Molina public website at Washington Medicaid - Provider Notices.