Check your own ABA billing before an auditor does.

Esta lección en español

A payer audit is not clever. It is five arithmetic checks run over every line you billed. You can run the same five checks yourself, on paper, this afternoon. This lesson shows you how.

What is a billing audit?

A billing audit compares three things for every session you were paid for: the **claim** (what you billed), the **note** (what the session record says happened), and the **file** (the client's authorization, evaluation and referral). Where the three disagree, the payer asks for the money back.

Nothing in that sentence needs a lawyer or a consultant. It needs a calculator and an honest afternoon.

Why it matters

Payers now run these checks by computer, across every claim, after they have already paid you. A pattern that looks small on one line becomes a demand letter when it is multiplied across a year. The practices that get hurt are rarely the dishonest ones. They are the busy ones, where a note says 105 minutes and the claim says 8 units, and nobody compared the two.

The BACB Ethics Code for Behavior Analysts makes accuracy in billing your professional duty, not your biller's (section 2.06, Accuracy in Service Billing and Reporting). Finding your own errors first is also the ethical position.

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How to do it yourself, today, free

Pull one month for one client: the claims, the session notes, and the authorization. Then run these five checks, in this order. The first one catches the most.

1. Units against minutes

Most ABA services are billed in **15-minute units**. The common codes are 97153 (technician delivering the treatment plan), 97155 (the BCBA adjusting the plan, often while the technician works), 97156 (parent or caregiver training) and 97151 (the assessment). Take the note's start and end time, get the minutes, and divide by 15.

Whole units are simple: 105 minutes is 7 units. The leftover is where payers differ. Many follow a rule that a partial unit needs at least 8 of its 15 minutes to count as a unit. Some do not allow rounding up at all. **Read your own payer contract for the rounding rule and write it at the top of your checklist.** Never assume.

2. Overlaps

One technician cannot be in two sessions at the same time, and one client cannot receive two one-to-one services at the same time. Put every session for the same person on one timeline and look for times that touch. Some payers allow a BCBA's 97155 to run alongside a technician's 97153 with the same client, because the BCBA is directing the session. If you cannot name the rule that allows an overlap, treat it as a finding.

3. Credentials on the date of service

The person who delivered the session must have held the credential the code requires **on that date**. An RBT certification that lapsed on the 14th makes every technician session from the 15th onward a problem, even if the renewal came through on the 28th. Keep a list of every provider with each credential's start and end dates, and check each session against it.

4. The authorization window

An **authorization** is the payer's written approval for a number of units of a code between two dates. Every session must fall inside those dates, and the month's units for each

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code must stay under the approved total. A session on the 2nd against an authorization that ended on the 30th of last month is not eligible, however good the session was.

5. The evaluation, referral and plan

Treatment needs a foundation on file: a completed assessment (97151) with its report, the referral or diagnosis your payer requires, and a current treatment plan, which most payers expect to be renewed at least every six months. If a month of treatment sits on top of a missing or expired one of these, the whole month is at risk, not one line.

The habit that matters most: when a check cannot be run because a document is missing, write *not checked*, never *fine*. "We did not look" must never read the same as "we looked and it was clean."

A worked example

MADE-UP CLIENT SAMPLE01, MADE-UP STAFF. NO REAL PERSON APPEARS ON THIS SITE.

Client SAMPLE01 has an authorization for 97153, 160 units, from 1 June to 31 August. Technician R. Vega is an RBT, certified through the end of next year. One September note reads 9:00 to 10:45. The claim for that date shows 8 units of 97153.

Check	What you find	Result
Units against minutes	9:00 to 10:45 is 105 minutes. 105 ÷ 15 = 7 units exactly. Billed 8.	**1 unit, 15 minutes, unaccounted**
Overlaps	No other session for SAMPLE01 or R. Vega that morning.	Clear
Credentials	RBT active on the date of service.	Clear
Authorization window	The session is in September. The authorization ended 31 August.	**Outside the window**
Evaluation and plan	Treatment plan dated 15 February; the file has no renewal.	**Plan older than six months**

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One session, three findings. Notice what the findings say: *15 minutes unaccounted*, *outside the window*, *plan older than six months*. They do not say overpayment, recoupment or fraud. Those words belong to you, your counsel and your payer. The audit's job is to find the gap and name it plainly.

Something to keep: the one-page checklist

Per session	Write down
Rounding rule	My payer's partial-unit rule: _____
Minutes	End time minus start time = _____ minutes = _____ units. Billed _____.
Overlap	Any other session for this client or this provider touching these times? Rule that allows it: _____
Credential	Provider's credential active on this date? Start _____ End _____
Authorization	Code _____ Window _____ to _____ Units used this month _____ of _____
Foundation	Assessment on file ___ Referral on file ___ Plan dated _____ (under 6 months?) ___
Anything missing	Write NOT CHECKED, not clear.

Try it

MADE-UP CLIENT SAMPLE02. AUTHORIZATION FOR 97153: 120 UNITS, 1 MARCH TO 30 JUNE. PAYER RULE: A PARTIAL UNIT COUNTS ONLY WITH 8 OR MORE MINUTES.

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Date	Note says	Provider	Billed
12 June	13:00 to 14:30	K. Osei, RBT active	6 units 97153
19 June	10:00 to 11:00	K. Osei, RBT active	5 units 97153
26 June	13:00 to 14:20	K. Osei, RBT active	5 units 97153
2 July	13:00 to 14:30	K. Osei, RBT active	6 units 97153

Two of the four rows have a finding. Which two, and what would you write?

– Show the answer

19 June: 10:00 to 11:00 is 60 minutes, which is 4 units. Billed 5. Finding: *1 unit, 15 minutes, unaccounted.*

2 July: the session is fine on minutes (90 minutes, 6 units) but the authorization ended 30 June. Finding: *outside the authorization window.*

Why the other two are clear: 12 June is 90 minutes, 6 units, billed 6. 26 June is 80 minutes: 5 whole units plus 5 leftover minutes, which is under the 8-minute rule, so 5 units. Billed 5. Correct.

Where DRAGEN helps

You now know the five checks. DRAGENaudit runs the same five over a whole billing export, every line, and writes each finding in the words you just used. It is arithmetic, not AI. It runs on your own computer and sends nothing anywhere. It never writes a legal conclusion. When a document is missing it reports the month as NOT CHECKED, never as clean.

Free on this page, and yours to keep: the lesson and its printable sheet. No email, no login.

Sources: the CPT code set for adaptive behavior services, 97151 to 97158 (American Medical Association); your own payer's provider manual for the rounding and concurrency rules; BACB

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Ethics Code for Behavior Analysts, section 2.06. Every example on this page is invented.
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