ACD Provider Information Meeting Transcript
Stakeholder Meeting #10
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[Coordinator] Welcome and thank you for standing by. At this time, all participants are in a listen-only mode until the question and answer session of today's conference. At that time, you may press star one on your phone to ask a question. I would like to inform all parties that today's conference is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the conference over to [Speaker 1]. Thank you, you may begin.

[Speaker 1] Hi. Good afternoon, and good morning, everyone. Thank you very much for joining us for the 10th Autism Care Demonstration provider information session. Appreciate you taking time out of your day. We have lots of good information I hope that you'll find useful to pass today and we also have a number of questions that you submitted that we'll be getting you some answers for. But before I do the introductions for the whole group, we're very pleased to have [Opening Speaker] who is the Deputy Director for the Defense Health Agency here with us this afternoon. And with that, I'd like to turn it over to him to make some opening remarks. [Opening Speaker]?

[Opening Speaker] Hey, thanks, [Speaker 1]. So good afternoon to everyone, and I'm stepping in on behalf of [the Director] who is actually en route right now to Portsmouth Medical Center to visit the market down there, but she did ask me to extend her greetings, and most importantly her regrets for not being able to attend this round table today. As [Speaker 1] stated, this is our 10th since I believe 2013, and we try to do this every four to six months, and clearly this has been a great forum to actually get the feedback from the community, and it really – this actually helps us shape the way we're heading in this particular direction in support of autism. I'm grateful for your ongoing engagement and input to our TRICARE program. As many of you know, we are undergoing probably the biggest change within the Military Health System, as it relates to the National Defense Authorization Act of 2017. And the only reason I mention that, it's a huge opportunity for us to really take a different look at many of the issues that confront us, to include the Autism Care Demonstration project that's ongoing right now. Autism Spectrum Disorder is a significant interest to the families that we serve and to our senior military and civilian leaders. This is a big deal for the Department of Defense, and it's a big deal for the nation. And where there's a possibility that we can lead, then we try to do that. But for those of you on the call who are providers, you've been the key to implementing this demonstration. And we want to continue learning from and building on your experiences out there with this demonstration. Going forward we'll be continuing consultations with stakeholders to identify best practices in the commercial sector, and use that as a guide as we develop a single nationwide contract for ABA services. We think that'll be good for our beneficiaries. Helping ensure consistent, high quality, coordinated care wherever our beneficiaries are.

And as you all understand more, so that they – as they move around that coordinated care is so important. And not just for autism, but for many facets of the – our health care system. So once again, I don't want to take up too much time. I realize that you all have a lot of questions, and we've assembled a great team that can, maybe, answer some of those questions. But more importantly, it's the collaboration that we're relying on. Not just today, but into the future. So at this point in time, and I pause as I'm not planning on staying through the whole session. But I did want to open up if you had any specific questions of me, and I warn you that I am not a clinician, so I will not attempt to answer clinical questions, but if you have broader strategic questions of me, please go ahead and ask me those questions at this time. Over.

[Coordinator] Thank you. We will now begin the question and answer session. If you would like to ask a question, please press star one, unmute your phone, and record your name clearly. Your name is required to introduce your question. If you need to withdraw your question, please press star two. Again, to ask a question, please press star (*) one (1). It will take a few moments for questions to come through. Please stand by. I show no questions at this time.

[Speaker 1] Okay, well thank you. Okay, well, I…

[Coordinator] I'm sorry, I do – one question just popped in, one moment please, I do apologize. First question comes from [Attendee]. Your line is open.

[Attendee] I have a question regarding credentialing of our registered behavior technicians and behavior analysts. We have been given several forms to complete in order to have them credentialed and, once we submit the form, it's taking an exorbitant amount of time to have them actually appear on the credentialed list. It's supposed to take 30 days and we have some that we have been waiting since January, and we're wondering if there's a process that we're not following or if there's something else that we should be doing.

[Opening Speaker] Hi, [Attendee], this is [Opening Speaker]. I apologize. I realize the moderator had mentioned we'll start the Q&A session. I probably misspoke. I was just looking if anyone had any specific question to me, I'm sorry, as the Deputy Director. And if there are none, then we'll continue. And I believe the Q&A session will start here momentarily. But I did originally just want to ask if anybody had any questions of me as a Deputy Director and also standing in for [the Director]. But if there are none, then thank you very much to everyone for your participation. And as I said before, we'll continue these into the future.

[Speaker 1] [Opening Speaker], thank you very much for joining us. We appreciate that. And we will address that question about credentialing before the end of the session. So let me then go ahead and get started with the introductions for our team here. And if the moderator would go ahead and close the line, please. So I'll introduce myself first. I'm [Speaker 1]. Many of you I think know me. We've met a number of you and some of you – I would echo [Opening Speaker]'s comments about how valuable we find these sessions. I'm the Chief Clinical Officer for TRICARE which basically means I'm the chief medical person for TRICARE, and am supported by an outstanding team. And I'm going to ask them to go around and introduce themselves. Before I do that, though, let me just make a couple of comments about our team. First of all, in the past, you've likely worked with either [ABA

POC] or [ABA POC] two outstanding folks who, I regret to say, although I don't think they're regretting it, but have retired. They are very much enjoying their retirement, but that means obviously we don't have them with us anymore. And they did a super job, so I want to thank them for the great work that they've done. But the good news is that we have back [Speaker 2], who many of you know was the – worked on the Autism Care Demonstration for quite some time before we let him break away for a little bit, and do great work on the T17 contract in bringing that to fruition, and also some of the changes that are coming now with TRICARE. But he is now back on the Autism Care Demonstration. We are thrilled to have him and all his knowledge and experience back. And I'll let him introduce himself here in a minute. I'm also pleased to announce that [Speaker 4], who has been with us for a long time, and was in the contractor status which limited a little bit what she could do, but she is now a government employee, and we are thrilled to have her in that role which expands what she can do. And she's going to be providing great support to the Autism Care Demonstration in an increased way. So we are very happy to have her. For those of you who don't know, she was an ABA provider, trained as well as a psychologist, so brings great knowledge and experience to our team. So with that let me go around and ask all of our folks to introduce themselves, and I'll start with [Speaker 3].

[Speaker 3] I believe that most people know me, as I've been involved in the Autism Care Demonstration in the previous iterations since 2012. I'm a psychiatric nurse practitioner by training, and I'm part of the team here, and I provide support to this endeavor. Thank you.

[Speaker 1] Thank you.

[Speaker 6] Hi, [Speaker 6], I'm a clinical psychologist. I'm the chief of the Clinical Community Support Section. Our name has changed, once again, but we support the clinical communities here in DHA; and complex pediatrics is certainly a major community.

[Speaker 4] Hi, [Speaker 4] here, [Speaker 1] already started my introduction, so I'll just pick up. I work alongside with [Speaker 3] and under [Speaker 6] in the Clinical Community Section.

[Speaker 2] All right, and I'm [Speaker 2], I'm the program manager for the autism demonstration. I'm a health care administrator by trade, so I'm happy to be back with the program. I actually asked to come back to the program when I found out that (ABA POC) was retiring. I think it's extremely important and I believe in what we do wholeheartedly. Thank you.

[Speaker 5] And [Speaker 5] with the Office of General Counsel.

[Speaker 1] Okay, so that is the autism care team here at defense health agency, like I say I think we have a really outstanding group of people here that are working to make sure that our military children with Autism Spectrum Disorder are getting the very best possible care. And let me talk a little bit about the current state of the Autism Care Demonstration, and then, we'll move on to talk about the future, and then I'm going to turn it over to the rest of the team. So just to give you a brief summary of where we are right now, right now we have about 14,300 patients in the Autism Care Demonstration. That number has been relatively stable over the last year or so. We have added about 1400 new patients in the last quarter. But we also had some patients who left the program, which is not unusual with people

coming and going from the military, and of course patient needs changing, but we also have – continue to have well over 20,000 providers, and have added 1600 new autism providers in the last quarter. Let me just say in advance, we very much appreciate the work all of you do taking care of our military children and some adults with Autism Spectrum Disorder. You do a great job; we get lots of great reviews. We just did a customer service survey that we hope we will be able to release the results on soon. But I saw a draft of that and I can tell you that people are by and large – the families are very pleased with the care that they're receiving, and that is certainly a credit to all of you and we thank you for that. The couple of other points, we are – as you know, we've started collecting metrics on the program, and I'll talk a little bit more about that when we talk about the future state, but so far that appears to be going fairly well. And when we talk about some of the changes coming to the manual, we'll talk some more about that. You may also have heard that, lately, there was an audit of some of the claims in the South region. And one company in the South region, separate from the audit, actually is in some legal difficulty about some of the claims they filed being potentially fraudulent. And I just want to note that we certainly, there's been some talk about that, and we've seen some emails about that. Certainly, I can tell you our opinion. I think very well – very certain is that the vast majority of providers are doing the right thing, are trying to provide great care to the kids. But we also recognize that a lot of times the key issue here is documentation. Now, obviously, in a fraud case, that's a little bit different. But we want to make sure that we're giving you information about how to properly document the care that you're providing so that, if there is an audit or a question, if the documentation is solid and everything's there that we need, that usually answers the questions very quickly. So we are going to spend some time today talking about documentation, and some of what we're looking for in documentation, because we really want to help ensure consistency and accuracy in how care is being documented. And we hope that will be helpful for you, as well, to kind of know what we're looking for there. [Speaker 2] is going to talk a little bit. We've had some concerns expressed, by families, about requirements that some individual providers may be requiring deposits or enrollment fees prior to starting care. So we're going to talk a little bit about that. I can tell you that, in general, that's not permitted under the TRICARE program. You cannot require a deposit; you cannot require an enrollment fee prior to joining treatment. But [Speaker 2] will spend a little bit more time on that. I'll also remind you that TRICARE itself is going to be undergoing some very major changes, here, over the next several months. First of all, we're initiating a new set of TRICARE contracts, as of January 1st, 2018. One of the changes with those will be that, as of January 1st, there will be two Regions, not three. The North and South Regions are merging to become an East Region, and the West Region will be the same, in terms of the geographic area. However, the contractors are changing. Humana Government Business will be the contractor for the entire East Region; so, the current North and South. And they will now be administering their own mental health benefits, so Value Options will not be part of the contract, as of January 1st. In the West, Health Net will be taking over for United, and we'll be administering the contract in the West Region as of January 1st. So for many of you, probably just about all of you, you'll be working with a different contractor here within a few months. I anticipate that probably for many of you, the new contractor has already reached out. If they haven't, they likely will be soon to talk with you and get a new contract set up with you. But be aware that that's a very major change. There's also going to be other changes coming to TRICARE. For example, right now, there's basically two kinds of TRICARE. There's TRICARE prime, which is the HMO option, where there's a primary care manager either at a Military Treatment Facility or a civilian one. And that person

basically directs all the care. And, then, there's TRICARE Standard, which is a completely unmanaged version of TRICARE, where the patient simply sees the provider, sends in the bill, and gets paid. TRICARE Standard is changing to something called TRICARE Select. [Speaker 2] was actually a very important person in helping us make this change. TRICARE Select will require enrollment, unlike TRICARE Standard, so patients and families will have to enroll in TRICARE Select. I can tell you that to make this easy on everyone, people who are currently TRICARE Standard will automatically be enrolled in TRICARE Select on January 1st, so we are hopeful that for the vast majority of our patients this will be a very seamless change. But certainly, going forward, you will need to make sure as you see patients that they are in fact enrolled in either Prime or Select before you take them on as TRICARE patients at least. So that's where we are right now with the current state of the Autism Care Demonstration, so let me talk a little bit about what's coming in the future, I suspect there's some interest on that. As you may know, although for those of you who are newer to these calls, you may not, the current Autism Care Demonstration expires on December 31st, 2018. Now let me say, first and foremost, that, obviously, just because the demonstration project ends then, does not mean care ends then. We absolutely will be continuing to be providing high quality outstanding care to children with autism well past 2018. So that will not change. What may change is a little bit about how we administer the program. Right now, we are using what we call demonstration authority for the provision of ABA, because under the law, everything that we do in TRICARE has to meet what we call a hierarchy of evidence, which means there has to be strong research evidence supporting whatever treatment or therapy that we pay for. At this point ABA does not meet that hierarchy of evidence. I can tell you that the Defense Health Board recently issued a report; their pediatric subcommittee recently issued a report. It's available online. It's titled *Pediatric Health Care Services*; you can get it on our Web site. And I can tell you I – autism is focused on pages 112 to 116 of that report. So let me summarize just briefly a couple of the findings of the Defense Health Board pediatric subcommittee, because we did ask them to look at autism and they did I think a very nice job of that. You may know that back in 2009, the Defense Health Board issued a report looking at autism care and at that time, they said that they didn't think that there was enough evidence regarding ABA to determine effectiveness. They updated that and basically their comment is that since the research since 2009 has been mixed on the effectiveness of ABA, they do a nice summary of that which I would certainly suggest – I won't read it to you here, but I would certainly suggest you read it. I think they did a nice job with that. Basically their finding is that at this time that it appears that ABA has at least short term benefits for some children with autism, but that it's difficult to know which children it will benefit, that long-term benefits have not been established, and that it's also unclear how much treatment is appropriate for each child. So basically, they say there's still quite a bit that we need to learn about ABA and I would certainly agree with that. And one of their strong recommendations for our Autism Care Demonstration in their report is we need to collect more outcomes data and base some of our decisions on that outcomes data. So again, I would recommend you look at that. They did find that they still continue to believe that ABA does not meet the hierarchy of evidence as defined by regulation and law. So that basically tells us that at least for right now, we're probably not going to be able to include ABA as part of what we call the basic TRICARE benefit, in other words those things that are covered automatically as part of the medical benefit. So we're looking at what our alternatives are. Certainly one possible alternative is extending the demonstration. We are looking at that. As [Opening Speaker] mentioned, we are also looking at the potential for changing how we administer the TRICARE autism

benefit. Some of you may know we recently had a request for information that the contracting process where we ask interested individuals to submit information about their recommendations, how we should move forward. We got a number of excellent submissions to that, and I know some of you on the line were among those who submitted information and proposals and we greatly appreciate that. Again, those I think were very helpful for us. Kind of the next steps for us is we're going to be meeting with potential providers of autism services on a contract for a nationwide contract as [Opening Speaker] mentioned. So we would be looking at basically carving this out from the regular managed care support contract, having a single nationwide contract, which might even extend beyond the continental United States. That's something we need to consider, but having a single nationwide contract that would manage the autism care benefit for all TRICARE beneficiaries. I can tell you one thing that is true for all medical care that we're providing and certainly will apply to autism as well, is we're moving very much to a value-based approach. I think this new contract that we're looking at would do that as well, and what I mean by that is right now most of what TRICARE pays for is what's called fee for service. Basically, you provide a service and we pay you. There is a move certainly within all of medicine, not just TRICARE, but commercial medicine as well, and things like Medicare, to instead of paying for the number of hours you see a patient or the amount of service provided, rather it's paying for the outcome, so getting paid more if children in your care tend to do better. And looking at the outcomes, that's one of the reasons that we're collecting outcomes data is because we need to know what works and what doesn't, and in the long term we may be able to use outcomes data to again, really do value-based care and reward those providers who are getting the best outcomes. And again, that's not just limited to autism. We're doing that for a lot of different things within medical care that's provided under TRICARE. So with that, I'm going to turn things over to [Speaker 2], who is going to cover some things. But before I do that, let me just again say thank you to all of you for joining us today. And very much thank you for the great care you're providing to military children. And really appreciate all the work that you do, and we look forward to working with you as we design the next phase of treatment in support for children with autism in the military. And, with that, let me turn things over to [Speaker 2].

[Speaker 2] Okay, thank you, sir. Good afternoon, everyone. The first issue that I want to talk about came to our attention recently. As you all are aware, the NDAA for 2017 placed the floor on reimbursement rates such that we were to pay rates no lower than those rates that were in effect in March 31st, 2016. And it came to our attention that one of our contractors was attempting to negotiate rates with some providers below that floor. Since we learned that, we've issued a letter to that particular contractor informing them that they are not to do that; that network discounts will not apply to those rates. And we are also going to go even further and we'll actually put that language into the TRICARE Operations Manual so it's crystal clear to our contractors that they are not to negotiate rates below the floor the Congress set for us as part of the NDAA 2017. So that letter was issued September 13th, and that contractor has until today to submit their plan to us on how they're going to comply. So that's all I have for that issue, I know that was one of the questions that was submitted to us. The other issue that came to our attention was that we were informed that several provider groups were informing parents that they have to agree to pay mileage, pay enrollment fees, and other fees in order to receive ABA services from that practice. And some groups even asked parents to pay a $1000 deposit in order to receive services. Providers should not bill the sponsor or beneficiary for services for which they are entitled

to reimbursement from TRICARE. Mileage and other similar expenses are a part of the administrative fees that are factored into the reimbursement rate. And they are specifically excluded in the TRICARE operations manual. That is very clearly outlined and any providers that are doing that are subject to not be approved as TRICARE authorized providers in the future, and also that is also a violation of 32 CFR 199.6 which states "providers may not hold patients liable for payment for certain services for which CHAMPUS payment is disallowed." So you may not seek payment from the patient or the patient's family if you're actually getting reimbursed for that service. And, again, continuing to do that, such practices, can result in a termination of authorized provider status. So that's all I'm going to say on that issue. I hope that's clear. Sir?

[Speaker 1] Okay, thank you, [Speaker 2]. So appreciate that, and I think you know, just trying to clarify that basically a lot of those things, like the mileage has already been figured when the reimbursement rates you're receiving, so you shouldn't be collecting from the patients because that would essentially be collecting twice. So appreciate that, and now I'd like to turn things over to [Speaker 3] to talk a little bit about testing.

[Speaker 3] Yes, good afternoon, everyone. I'm going to just review what's going on with the testing requirements, and for the next few topics, we'll review some of the potential changes to the TOM, to the ACD policy, and please remember that these revisions are not yet final or approved and they're subject to change. This is one of the reasons that we have the round table/information sessions/sensing sessions whatever we are calling this interaction. So none of the changes are being implemented at this point in time, and they will not apply until the manual is published and implemented, so this is in the works now. So as we discussed during the last round table, which was actually our 9th gathering, which was on 3 March 2017, and again in May 2017 with the issuance of the common letter that went to our regional contractors, the outcomes requirements that we originally had included in the November 29th, 2017 TOM revision have been modified to include requiring the Vineland every two years and the SRS-2 every two years with the PDDBI being selected as the progress measure to be completed by the BCBA every six months. And just a reminder that we also, in the policy, will include language to allow submission of the second edition of the Vineland, the Vineland 2, until the end of this year, which is December 31st, 2017, and that is because as you will recall, the third edition of the Vineland has been published, and after consulting with the publisher, we have determined that it's appropriate for allowance of the Vineland 2 until the end of this calendar year on December 31st, 2017. Starting January 1, 2018, which I realize is not that far off in the future, only the third edition of the Vineland or the Vineland 3 will be accepted. And then I want to talk about eligible providers, because I know that as you well will recall from our 3 March round table and the communications that have continued since, that there was a concern about providers who would be available to collect these outcome measures. So in response to this, and I do want to say that this is not implemented at this time yet either, this will be implemented with publication of the TOM revision, which is pending, but you will recall that this was an issue, concern over who – available pool of providers to do the outcome measures. So we in response to this, are expanding the types of eligible TRICARE authorized providers who can complete the Vineland and the SRS2. So in the draft of the manual, and it is paragraph 8.2, you can see that the proposed language for the Vineland and the SRS is that these measures can be completed and submitted by – and I'm just going to list these different groups, the TRICARE authorized individual provider with an independent scope of practice, and this

means the TRICARE authorized independent providers as defined under the TRICARE manual for Basic programs. This would be developmental pediatricians, psychiatrists, child psychiatrists, psychologists, child neurologists would be among this group, certain doctors in nursing practice meeting criteria to be authorized providers, and that these providers would use the assessment code for their discipline for reimbursement. We also are adding that a BCBA or BCBA-D can also collect – can obtain the Vineland 2 until December 31st, 2017, and then the Vineland 3 and the SRS. Parents and caregivers can provide the TRICARE authorized independent provider or the authorized ABA supervisor a school-completed interview or teacher form for these measures, to the regional contractor to meet this requirement, and if you, recall if you've been with us for a long time, you will recall that in the past we also had accepted some school completed forms. But then as of now this continues as well, if you receive a form completed by the school for submission to the contractor, then the submitting provider would not be eligible for reimbursement because the outcomes measures were not completed by the TRICARE authorized independent provider. Bottom line the type of provider to complete these measures is greatly expanded under the revised ACD policy. I do want everyone to be aware that we have not worked out the process yet for how this will happen. We will be working with the regional contractors and once that is defined, that will be included in the policy, so as I stated before, this is not implemented yet, not until the policy is published will it be implemented, so please, folks, don't go running out and getting Vinelands and SRSs on your folks now until we define the process. So more will be forthcoming with the TOM release and we hope to have clear and precise guidance as to what the process will be, and we firmly believe that this expanded pool of providers and the simplified measures should make it much less cumbersome and much easier to have these outcome measures completed. And now I'm going to hand over the next topic to [Speaker 4].

Speaker 4] Hi, so I'm going to talk about the proposed language for BCBAs to have a reimbursement code for if you are either wanting to or identified to subsequently complete the outcome measures. Because BCBAs don't have or the TOM doesn't have a separate assessment code for these psychometric measures, we had to do something, create something that could facilitate that opportunity. And what we did was, we identified a code, we actually made – had our coding and reimbursement folks help us come up with these proposed T1023 claim number or reimbursement option, and the reimbursement is going to mirror that of the psychometric testing code used generally by the psychology folks, and we're going to use the reimbursement structure for 96102. And that one was selected because it is a non-doctoral level reimbursement code. So essentially this is the code that you can – it will be detailed in the TOM, clearly, but you will get one unit for every measure that is submitted, but one unit in its entirety, so if you have multiple forms, still just one unit. Let me make sure I got all of the right – yes, so I have all of our elements, so you'll get one unit every six months for the PDDBI, and then one unit every two years for each of the measures. Again, this is not approved yet so this is draft language, and again to echo [Speaker 3], that you will have to be identified as the provider, so please do not submit it and expect reimbursement if you are not identified.

[Speaker 1] [Speaker 4]

[Speaker 4] Sure.

[Speaker 1] Yes, may I say one thing? Now, this T1023 code that has been developed in consultation with our coding experts will be for use when the BCBA or BCBA-D is the designated provider to complete the Vineland or the SRS-2. There already are existing assessment codes that a clinical psychologist or physician would use.

[Speaker 4] Right, and you would use those – so those other disciplines would use their discipline-specific assessment code, so like psychologists would use the 96101 and 96102. I – the pediatrics department, I don't know their coding well enough off the top of my head, but I know there is an assessment measure for them too, so they would submit it that way. So great, I think the next topic is back to you, [Speaker 2].

[Speaker 2] Okay, thank you. Okay, then, the next area I want to cover is the recent DoD inspector general audit of the South region. The South region did conduct an audit, and they found a lot of indicators of improper payments, valued at over $3 million of overpayments to providers, and some of their major findings included a lack of documentation to support ABA services, misrepresentation on who was actually providing the ABA services. Commonly the submitting claims were at the BCBA rate when the behavior technician was the one who actually provided the services. Billing for services while the patient or beneficiary was actually napping; billing for two or more services at a time; unreliable supporting documentation; even billing for services when the beneficiary wasn't even present. So there were several recommendations that the DoD IG gave to us and, as a result, we will be revising the TRICARE Operations Manual to put in place some more oversight to ensure that these kinds of things don't happen in the future. Among some of that, the oversight that's going to be put in place is we'll be asking our contractors to conduct post-payment analysis of all ABA claims to identify providers who show indicators of potential improper payments. And some of those indicators will include a high percentage of claims paid at the highest rates; billing for six or more hours per day. Let's see, those will be two of the main indicators, and so we will also require our contractors to take corrective action when they suspect improper payments are taking place, and not limited to payment recoupment. Also, they will be required to refer any improper payments to the Defense Health Agency Program Integrity office, as appropriate. So that's the bottom line on that issue. There is an ongoing audit in the North region right now, and there will be an audit in the West region. We take this very seriously, and we are going to put in place some more oversight procedures and require our contractors to follow them diligently. So sir?

[Speaker 1] Yes, thank you. So this is [Speaker 1], if I could just follow up on [Speaker 2]'s excellent discussion there, I think the key thing for us is what we know about what happens with children who are relying on us for care is what's documented in the record. That's why documentation is so important to us. And none of these things that [Speaker 2] just mentioned, having a high percentage of claims paid at the highest rate or billing for more than 6 hours in a day is necessarily bad if it's correct. But the key thing is documentation has to be correct, it has to be accurate, and it has to really show what happened with the child that day. So when we get a bill for BCBA and it's actually – and the record comes back and says a BT provided the service, then we have a problem. If the record shows the child was sleeping during the time we got billed, again, there's an issue there, and a big issue a lot of times too is simply the documentation doesn't say what happened. We don't know. And if the documentation doesn't tell us what happened, then it's very difficult for us to determine whether the billing was accurate or not. And we need to be able to use

documentation to verify that. And again we're really trying to make sure that our children, the military children that we are responsible for are getting the care they need, are getting outstanding high quality care. And that's really our primary focus here. Certainly we're worried about, if people are taking money from us or fraudulently billing that's a concern to be sure, but really our number one focus is what's happening to the children and are the children getting the help they need when and where they need it. And I will tell you for example, in the one case we did have in Florida that you may know of, where a senior – basically senior manager of a large practice there, that was providing a lot of mental health services to military children, not just ABA, has pled guilty to fraud and knowingly modifying records. What we did in that case is that practice is likely going to be excluded from TRICARE for a period of 10 years, but we immediately worked to move all the children that practice was seeing, which was several hundred, to other providers, and we were able to do that very quickly as Humana and Value Options did a great job with that. And we made sure, our number one goal was minimizing the disruption and the harm to those children and their families, because that is always our primary focus. And so in those cases where we have to do that, we will move very quickly to make sure the children are getting well taken care of and are getting the services they need. And that's always our primary focus, so I wanted to make sure you heard that and know that that's really where this is coming from, is that we need to make sure the kids are getting the care they need, and that's really what's most important here. And so with that, let me turn things over to [Speaker 4], who is going to talk a little bit about how documentation needs to be done, appropriate documentation that will reach the goals that we just discussed, making sure that we can verify that what's being billed is in fact what's being provided, and that the children are getting the right care and the care that will help them reach their maximum potential. So [Speaker 4]?

[Speaker 4] Thank you. So through these audits that [Speaker 2] mentioned and then some through other opportunities of audits, we've had the opportunity to look at progress notes. We've had the opportunity to look at treatment plans, and we're hoping to use this time to go CPT code by CPT code and really tell you what are the general expectations for appropriate medical records documentation. And when I'm done with that, then I'll talk about the claims – the appropriate claim form completion that would go with those codes. So I'll start broadly, so we have listed in the TOM the requirement for documentation of progress notes, and that actually doesn't come from a made-up ACD TOM section. That comes from 32 CFR199.2, and there's a definition, medical record documentation. And then in the TRICARE Policy Manual, that reference is Chapter 1, Section 5.1, and that title is Requirements for Documentation of Treatment in Medical Records. And in that policy, you can find the required elements. We've also listed them in the TOM manual, so there's a cross-reference, but in TPM Chapter 1, Section 5.1, it's actually paragraph 4.3 that I'm going to be quoting here verbatim at this point. So those required elements are: dates and time of sessions, the length of the therapy session, so if you had a two-hour session, a three-hour session, something like that, notation of the patient's current clinical status evidenced by the patient's signs and symptoms, so the contents. I'm sorry, the – like a mental status exam. Were they alert? Were they participating? Were they frustrated? Were they that kind of stuff. The content of the session, so what actually you did, and we'll talk about some of that as I go code by code. And then a statement summarizing the techniques attempted during the session, a description of the response to that treatment or the outcome of that treatment or the response significant to that session, and then a statement summarizing the

overall progress. I think that sounds familiar to everyone, and then what's in this TPM reference is progress notes should intermittently or at least on a monthly basis include reference to progress regarding the program in its totality, so its goals, its treatment plans. It should tie back to why they're actually there. And then we added into this revision some extra information because we found that this was a consistent missing element, a legible name of the rendering provider. Oftentimes, we either found initials or something that looked like a signature, but we couldn't identify who that was. And then we also are including the individual provider credentials, so if you're a BT, if you're a BCBA, those elements will be required. And then lastly the actual signatures, every note should have a signature whether it's electronic or hand, there should be a signature reflecting that session probably on that day. I mean, I – we understand that maybe notes aren't completed the same day, but months later should not be the date on that note. Okay, so the majority of that was from the TPM reference, and you can find that on the TRICARE manual Web page. I can give that entire reference if necessary, but we could also put that in the Q&As and in the transcript that will come out after this session. So now that we've talked about the broad description of what's required in the medical record notes, I'm going to take a few more minutes to discuss each CPT code. We'll start with 0359T, the assessment and reassessment code. I'm actually not going to spend a whole lot of time on this one because I suspect that every time you are issued an authorization and submit a treatment plan you are getting lots of feedback on how that treatment plan looks, whether it's the goals, whether it's any information missing. So I'm going to leave that one to the regional contractors to deal with because I think they've had – at least I've heard that they have had – definitely one on one interactions with many of you on treatment plan documentation. Just a reminder too that these treatment plans should be looking at medically necessary goals or clinically necessary goals, so I want to highlight that educational goals, vocational goals, daily chores, etcetera. Maybe things like – I'm recalling a particular goal that we saw that would be inappropriate, so teaching somebody how to text is not appropriate for a clinical or medical goal, so just a reminder that we are looking at clinical or medically necessary and appropriate services that are for the TRICARE ACD treatment plans. I'm sure there are other opportunities, maybe through the school, maybe through other community services or other centers that might have non-medical goals. And that's perfectly okay, but not for TRICARE's treatment plans. All right, next I'm going to spend some time talking about the 0360T and 0361T which is the – how we have modified the supervision code. This documentation should be a narrative summary of the supervision session, completed by the supervisors, not the behavior technician. We have seen a handful of folks turning in – it appears to be a checklist and I believe one of the board certifying bodies has provided a template supervision form, and we want to note that that's maybe what is required for your supervision requirement to maintain your licensure or to move up in credentialing status but that is not an appropriate documentation for a medical record. We really are looking for the content of said supervision session, so what did you do with that technician? Were they receptive? Did they understand? Did you spend a lot of time demonstrating? Did they adequately demonstrate the technique or the skill? We've seen some supervision progress notes that have one sentence or just chunks of words strung together such as job well done. Again, that's not a medical record notation. It really doesn't tell us what was clinically provided in that supervisory session, so we just want to highlight that these need some extra attention. Another thing, it would be good to connect what the supervisory session is doing with regards to the BT and the techniques, so I might say, technician A worked on pairing with the individual and response was… And you would describe how they got along, what did

you support them on? What were the questions that the technician asked in return? Just whatever that – we don't need like a timeline of what happened. You're looking for that qualitative summary of what was provided. Okay, so next we'll move onto the one to one code, 0364T and 0365T. Every rendering provider for the one on one session must complete a narrative note for reimbursement. Not completing a note is not an option. You will not get reimbursed if you do not complete a note. That I'll start with. So we've seen data collection being submitted for the note, and we recognize that that's definitely a part of your one on one session, part of the documentation. But there also needs to be that narrative component. The narrative component needs to have elements such as did the child comply, were there any difficulties or issues maybe with any particular target or goal generally? Essentially, we're looking for a description of what took place. Again, not to be confused with – we did A and then B and then C and then D. That's not the contents of a medical note. You might want to also include things in this session note that reflects what's going on in the kid's world, so kid didn't take a nap today; parents reported that they skipped a dose of medication; parents got back from a vacation and have noted increased behaviors as evidenced by... You want to include these things to help give context because again data points, while they're great, they don't give us the whole picture of what's happening. And when we look back in – I mean, as of having been a provider and knowing the bigger picture, I want to know what's getting in the way. What are the road bumps or hiccups? Road blocks, that's the one I was thinking of. And the qualitative information might help with things like kid missed a nap today or parent deployed yesterday, kid is not managing well. So those are good things to be included. Again, these should be several sentences long, One or two is not a sufficient note. And again the data points in and of themselves while useful don't help us provide the bigger picture in the child's overall plan – progress towards their plan. Okay, the next code we'll talk about is the 0368T and the 0369T. We had a lot of questions recently come in about the content of that form, seeing that we've modified the code and permitting a variety of things. Mainly it's the treatment protocol modification code which should be the BCBA or that responsibility delegated to the assistant. But that session note may be a change in the treatment plan. That could be one type. The other is a narrative of what the BCBA did, so maybe your goal didn't necessarily change, but you tweaked techniques or you tweaked the tools or the data recording element. But there should be again some sort of narrative documentation of what happened in that session. And then lastly we have the 0370T, which is the parent guidance code. This documentation is probably closest to the one on one code. We want to know who was there, what happened? How did things go? How did the parents respond? Did they have any questions? Really anything of notable importance that I think the supervising provider could benefit from when looking back towards the last six months of care and what worked or didn't work. So just a reminder about the notes that once you write a note, that's it. That is the medical record. If you want to add something later that's fine, you can add an amendment, but you cannot erase things. You cannot white things out, you can't change the contents. You can only keep adding, and those would have a subsequent date and time and a signature.

[Speaker 1] [Speaker 4].

[Speaker 4] Sure.

[Speaker 3] I recognize – this is [Speaker 3] – that there may be times when a person starts to write a note and they realize they've made a mistake, say. But they were writing a narrative

on the wrong patient, and they said oh no, I'm on the patient. You are allowed to put one line through and put error, your initials, date, and time, and then continue your note. So I don't want people to leave and think that there is no mechanism in medical documentation for honest mistakes. But you must document your note, date and time it, sign it. And if you have addendums, you can add them later. Thank you.

[Speaker 4] One more thing about the – well, two more points I have. One is about the reimbursement of these codes. Remember please that these are reimbursements for direct services, except for the 0370, but remember all of them are for direct service time, and this includes your pre and post work. So whatever you need to do to prep for the session, whatever you need to do for post work which includes the session notes, you cannot be billing an extra unit for note documentation. That is not a permittable medical practice. And the last thing I wanted to point out is that we have I think over the last handful of round tables, information sessions, and it did come up again in the DoD IG South audit, the findings about concurrent billing. And what we mean by that is billing for two direct services at the time, which means the beneficiary would be the focus of each. So the most likely example and this is where we have had the questions is with supervision and one to one, can people bill those at the same time. And the answer continues to be no, that the beneficiary is the center of each of those codes, and therefore that would be not permitted. Now I do want to take one more opportunity to say you can't bill for those two direct services, but you can bill for something like the BCBA is working with the parents and then the technician is working with the child. Those would be permitted, but you need to document that adequately. One other clarification is, where the beneficiary is the center of that session is you cannot be billing for ABA, so one to one ABA and another service such as speech or physical therapy or a dental appointment or something where there would be two claims at the same time with one provider. You can't be delivering two services to the same person at the same time. I think that is all I have for documentation purposes. Are there any around the room? It looks like…

[Speaker 1] I have a question, just a question that came to me that may help the providers, the codes 0368T, 0369T, which are for the treatment protocol modification, right? We also have allowed for treatment team meetings, correct? So how – do you have any like words of wisdom, pearls to share with the ABA providers on how to document for the treatment team meetings? Because that would be with the beneficiary present, correct? Okay.

[Speaker 4] Correct. I think it's the same kind of concept. You want to address what is the content, what was the clinical purpose of that gathering, so we looked at – it was the quarterly meeting where we address strengths and weaknesses of the program. We had everybody on the team demonstrate and practice in front of one another, ask questions, engage parents, whatever the purpose was for that particular get-together for the treatment team meeting. It needs to be a narrative of what was changed or what was addressed, how were the clinical elements of that session – how did that proceed?

[Speaker 1] Thank you.

[Speaker 4] No problem. Okay, so now we're going to move on to the claims piece, claims documentation piece which obviously goes along with every session that occurs. Like I said, through the audits, we've been able to see the claim documentation, and I think the DoD IG

South audit mentions some claims issues. I would think that the upcoming audits will have similar identified concerns so we just want to take that opportunity now to do that. And I really want to do that in support of what the contractors and the claims folks for each region have already put out; what's available on the Web sites; what the provider notifications; Webinars that they have done so well with. And I encourage everybody to continue to reach out to your contractors, because they are the ones who can best facilitate all of your questions, as I, while I'm familiar, probably can't solve your original like the root of the question, but I can help out here by echoing what the contractors and the claims folks have already been doing. So we'll focus on one claim line in particular. You guys have three ways to submit claims, generally. One is through the CMS form 1500, the other are through – I'm sorry, one is the provider express claims, and then there are two other ways with assistance through your own company to submit claims. The line number in which this applies I'm not sure, because I'm not familiar with each one. But essentially on the Claim Form 1500, the – if you guys want to be looking, it's line 24 that we'll talk about here for a little while. And line 24 A through J, we'll focus more on some of the letters than others. I also want to echo that you can find this claim form on the Internet. You can also find guidance on how to complete those forms on the Internet. CMS has put out a great descriptor for each, so this isn't us. This is medical benefits at large, so let's start with the first one, 24A, which is the dates of service. I think this one is pretty straightforward. The month, day, year of the session. 24B is place of service. I'm going to spend a little bit of time here because I think this may be confusing for some folks. Generally, the claims that ABA providers are submitting fall into three, possibly four, and now there's a fifth claim place of service. If you Google place of service you'll come up with a list of something like I don't know, 50, 60 options, so really you guys are only eligible for about three or four of them, so I'm going to take a minute to talk about them. So place of service 03 is school. We've seen this submitted previously. Remember that school services are only those authorized through the treatment plan, and you can reference the TOM on the requirements for getting goals such as that approved. The next place of service is 11 which is the office setting, so that would be a provider office, whether it's a center based office or an individual provider's individual location. And the other most common one would be place of service 12, which is the home. That's where I would expect to see a majority of the services, but I recognize there's a shift in and maybe even a balance in office versus home setting. We've seen some – I want to use the word funky, maybe that's not so professional, but notations in the place of service with a list – some providers are listing two places of service. You can't actually be in two places at one time, so I would really encourage you to just be using one of the options. You can't be both 11/12; that is what I'm seeing people submit. We're not actually in the office and the home at the same time, so if – and if you are changing locations, those should be separate claim lines. Having said that, the one number that I've seen that I encourage people to stop using is place of service four. That's the definition of POS #4 is a homeless shelter. I am not sure that we are having beneficiaries receiving ABA in a homeless shelter, so I would just encourage everybody to double check that one. The other odd one might be place of service 99, which is considered the unspecified [setting]. And I would predominantly suspect that one would be if you're doing a community-based session, so a treatment target would be like a socialization skill, or I mean, really anything, but I was trying to be concrete. 99 would be the unspecified codes, so not the home, not the school, not the office. But it should be rarely seen, but I do recognize that it could be. Oh, and there's one more, so the fifth code that I wanted to mention was as of August 28th of this year, so not even a month ago, the telemedicine policy was revised and published and

the 28th was its implementation date. What that means is that there's a new place of service code 02, which is the telemedicine place of service code. If you are providing remote supervision, you must include both the GT modifier as well as the place of service 02. We have been told that, as of August 28th, that your claim will be rejected if one or both of those elements are not there. So if you have 02 and you do not have the GT modifier, that will reject. If you have GT and do not have the place of service 02, that will reject. Or if you put 02 and it's not supervision, that will reject. But I wanted to point that one out because that's a relatively new change to the telemedicine policy generally. Okay, let's move on. 24C is the emergency designation. I don't think that applies to any providers here so we'll just gloss over that one. 24D is the Procedure, Service, or Supplies. That's where you list your CPT code and the GT modifier if that is for supervision. That's about all for that one. 24E is a diagnosis code. That's referenced to your diagnostic section that you've submitted on a previous box on the claim form. 24F, this is your billed charge, again that's pretty straightforward. 24G, this is the number of units that you have for the session, most of you are pretty good with that one too. I would encourage that you double check that what's on the session notes, it also matches the claim line. We noticed that there are some discrepancies sometimes, so just double check that one. 24H is the Early and Periodic Screening, Diagnostic, and Treatment; the family plan section, I don't think this applies to any of our ABA providers either. 24I is for emergency services, again that doesn't apply to this population generally. And then lastly there's 24J, and this is the last one that we'll spend a little bit of time with, because I think this one has caused the most confusion or the most problems when it comes to these audits. This is the line for the rendering provider, and that rendering provider must be the rendering provider on that specific session note. The supervising BCBA's NPI number is not the number that belongs, unless they're the provider, but that NPI number is not the number that belongs on that claim line. The correct information is – it's either going to be the rendering provider's NPI, so if the BCBA was the one that did the one on one session, then that number goes there. Or if applicable, I think it's the either social security number of the rendering provider or the carrier number which is I believe identified by the regional contractor. And I'm going to defer the subsequent questions that are probably going to come of that to the regional contractor, because I wouldn't – I am not familiar with the – how those numbers are developed or identified for each of you, but that's the number – the rendering provider's information goes in that line. There's one more thing that on these electronic claims that I want to make sure we point out. And that's if you are submitting multiple sessions on one day, you will be required to submit the time for each of those sessions, and I think just getting in the practice of identifying the time, regardless if it's just one session or multiple sessions, because essentially what happens is you submit a claim for multiple sessions in one day. And the first one will automatically get paid, and then the rest will deny. So unless there is that information, that distinct information of the session times, that will – you'll just have a lot of questions when it comes to why did I get denied, and I believe on the electronic forms, these are – these options for adding this time are in – it's what's called loop 2300 and loop 2400. Those are two places where you can put the actual session times for each claim line. Again, just to recommend getting in that habit because I think it'll save everybody lots of time and heartache down the road. And one more thing I wanted to thank all of our claims processing folks. I know you guys get tens of thousands of claims every day, not just for ABA but for all other services too. And we here really are appreciative of you support and help, not only for us, but also for the individual providers. I'm sure you get many phone calls and we thank you for that extra support. All right. Yes, here you go.

[Speaker 1] Thanks, [Speaker 4]. So thanks, [Speaker 4]. I know that was fairly lengthy, but I think very important, and I appreciate [Speaker 4] for doing that and being so thorough with her coverage of documentation. As I mentioned earlier, that's a very important area. I know there was a lot of information there. You may have some questions. And at the end we'll talk about how you can send us some more questions, but we will also be posting a transcript of that so if you didn't get it all the first time, which is very understandable, you'll be able to go back and read through the whole thing. So with that, now we'd like to move onto the Q&A, basically going over the questions that all of you submitted in advance. Thank you for those. We had some excellent questions, and I'm going to turn it over to [Speaker 2] to start, and then various members of our team will go through and answer the questions that are in their areas of expertise.

[Speaker 2] Okay, thank you, sir. First several questions we received concerned case management, and the first one was: who can providers speak to or beneficiaries speak to if the case manager is not returning phone calls? I would say that you need to contact the ABA number for the customer service number for each of the regional contractors and ask to speak to the Autism Care Demonstration program manager for that contractor to express your concerns. Each of the contractors does have an individual designated to run their program. And then, if that problem continues, you can certainly get a hold of us, and we'll post the ACD mailbox address in the Q&A and then it'll be in – we'll put it in the transcript or in the Q&A when we post it on the Web site. Excuse me. The other one is: is there a way to communicate with the case managers via email, and then there were some questions about using fax numbers? We will go back to our TROs and look at what the business processes are for communicating with the case managers. We need to do a little bit more research on that and see if there's a better way to implement better business processes to make sure those lines of communication are open. So we'll take that on and we'll give some more information on the Q&As that we post on the Web. Last is for an admin type question is: can the TRICARE regions include approved authorizations in the portal for providers to pull instead of waiting for faxed authorizations? Again that's another business process, and we'll look into that, but I – but we, that may be part of the TRICARE 2017 contract requirements. So we'll get a definitive answer on that to you. Excuse me. Back to you, sir.

[Speaker 1] Okay, thank you, [Speaker 2], appreciate that. So next question is about appeals process, and basically asks: the regional contractor is placing BCBAs into conflict with the compliance codes regarding too abrupt treatment of – abrupt termination of care, sorry. When treating providers are given less than 14 days' notice that a child's services will be terminated through the ACD. The question then is can DHA allow a 30-day window after a determination is made to allow the parent or provider to appeal the decision, or at least to prepare a transition plan? So I think a couple points here are key. First is I think one way to help avoid this is to make sure you're submitting your treatment plans as much in advance as you can. You can submit the new treatment plan up to 60 days before the expiration of the current treatment plan, which – so I would strongly encourage you to do that. Because if you do it 60 days in advance, you'll get an answer back fairly quickly, and if by some chance it is denied, you'll still have time to do the appropriate wind-down of the treatment. So I think early submission is a key point here. The second point I would say is that we don't determine what TRICARE does is we determine what we pay for. We don't actually determine what treatment you provide to the patient, so, there's nothing stopping you, in that case, from continuing to see the patient to do the appropriate termination, you're not

able to bill for that. You can't charge the patient for it. And I realize that's an issue; but, you actually could do that rather than violate the ethical guideline. So that is certainly another option that's open to you. And I will also tell you that we actually looked at – there was concerns in one region about denials, so we actually looked at it, and it turns out that very few cases actually are getting outright denied. What is mostly happening (of the 400 and some cases that went to second level review), what happened in the vast majority was there was some change to the treatment plan or perhaps a reduction of hours or a change in the goals. But very few, only - I think - six that actually were – had a final outright denial of services. So in most cases, what we're seeing is a change - not a denial. But in those cases where there is, again, I think both early submission of the request and, certainly making the choice on your own to finish out the termination process should address that. The second question is will we allow services to stay in place during the appeals process? That was submitted to us. That's obviously a bigger question than just autism, or I'd be looking at that across all of our services in determining that, and I can tell you that currently for any TRICARE service, we do not permit the service to continue during an active appeals process. However, I would note that, until the old authorization expires, it's still in effect. So if you use that 60 day period, if you do need to file appeal, while the old authorization is still in place you can still use it. The denial only applies to the new authorization, it doesn't terminate the old one early. So again, another good reason to get things submitted early. But we are also looking at – we do have something called the TRICARE modernization workgroup, which looks at all things TRICARE and what we should do to improve the benefits. And that group is actually looking at the whole question of appeals and how we should manage that. So for the time being the answer is once the old authorization ends, if there's an appeal in place, you cannot provide services and have them reimbursed by TRICARE, but we are looking at that and will certainly keep you updated if that changes. And with that I think we're onto [Speaker 4].

[Speaker 4] So following from [Speaker 1] talking about authorizations, there was a question submitted: what is the timeline for approving authorizations? And I think generally each of those regional contractors have a targeted timeline, but we here are not going to put a particular number to that, because I think there are a variety of factors that impact an authorization approval such as if the treatment plan has changed, are those goals or not? Does it need to go to another review? So the point is, is that each region has some – has a timeline that they're shooting for, but we recognize that there are variables that can impact – I think some of the other ones too that may impact are – is this the first authorization, is it a renewal? I think the other big one might be is everything actually in the authorization requirements? Have you met the minimum criteria to get past that first review, so that's that.

[Speaker 1] Okay. [Speaker 3] is up next.

[Speaker 3] Okay, this question came in about BLS, CPR requirements. I will read it. The BLS/CPR requirement for completion of a live course that includes practice on a dummy represents an added expense for TRICARE providers that is not incurred when providing services to civilian counterparts. A proposed solution is to consider eliminating the live course requirement or modifying the requirement to state that at least one person present during treatment must complete this requirement. That will allow providers to use center-based services to limit that training to full time center employees, which will substantially reduce the cost to the requirement (including the cost of the course) and paid hourly wage

for the hourly employees attending the training. All right, so we reviewed this, and the regional contractors cannot track which providers are or are not providing center based services. We have no mechanism for that, nor would it be reasonable to expect that one person in a facility who is trained in BLS or CPR would be present and/or available at the time you need, because of vacations, days off, sick time. With the high frequency of comorbid conditions such as GI or respiratory conditions, as well as the high frequency of the use of edibles as a reward and subsequent risk of choking, DHA is not willing to risk beneficiaries' safety for the cost to the provider. But what we have determined is that we will continue to require completion of the live course for the initial baseline training for all providers; but, that the every two year follow-on updated courses can be completed online after the initial course. So that will be up to each provider and each center-based practice to determine which course offering you want to take after looking at these. We see that, like the American Red Cross and the American Heart Association courses, do have an option for online within a shortened live dummy section. But there are other companies that offer the follow-up training completely online. So we will allow that, and we will put that in the TOM that after the baseline training, which everyone must complete and must be done live, can be done online. Thank you.

[Speaker 4] So I'll take the next one. This question was submitted, the topic is the BT supervision requirement. Essentially, the question submitted was: currently the technicians are required to have the 5% supervision for the direct – for the client per client per month, and what was submitted was that this doesn't actually sync up with what the BACB how that 5% rule applies. And there – the question is stating that this is a barrier associated with longer wait times, and that per technician per beneficiary per month is over what the certification requires. There were some scenarios listed as the second part of the question so I will do the first part and then go back to the scenarios. We are aware that we have a discrepancy with the BACB, but I think our focus is on the care and the quality of care provided to every single beneficiary. And essentially, there's the risk that there would be beneficiaries who would not have supervised technicians month after month after month. And I don't think that's something that we, at this point, are willing to compromise on. And we want every child to have the best care to include treatment fidelity to include oversight of the technician, which is the point of the supervision code. So at this time we're going to stick with our 5% per month per beneficiary per technician, and I think too in light of what's going on in the audits, this is a quality measure that we're tracking and again we're going to stand behind this one. The other part of the question was submitted about what happens when a technician is sick? Or, the child is sick? Or, the tech goes on vacation? Or, the family goes on vacation? Or, what happens if there – the number of hours aren't met? Or, what does that do for the practice, the provider, the technician? I think we all recognize that life happens, and that families do go on vacation and that people do get sick. But that really doesn't change our supervision requirement on the whole. However, reasonable guidance is to engage directly with the regional contractor to figure out how to negotiate these situations; because, again, if this child is out three out of the four weeks, are you actually going to get that 5% in? I'm not sure. But I would think that correctively or, as it's happening, you could be engaging with the regional contractor, because they're the ones who can reach out to us directly if there are any questions or concerns. But again, we at the DHA level don't have that direct visibility of case after case. [Speaker 3] you're up.

[Speaker 1] [Speaker 3]?

[Speaker 3] Okay, this question came in about CPT codes specifically, CPT code 0373T and the 0374T. We do not, TRICARE, allow the use of these codes. These codes are for when two BTs are required to protect the health and safety of the patient and/or the treatment team, and these codes are called Exposure Adapted Behavior Treatment. Generally speaking, in the CPT 2014 Assistant, these codes are used in a center-based care setting for physical restraint. TRICARE, we do not cover these codes. We have reviewed the field of behavior analysis 2010 statements, there's a policy statement that your field have to be written about restraint and seclusion. It's written by the society for the advancement of behavior analysts. And it outlines your field's position regarding the use for the protection of the beneficiary, on the use of restraints, and we have determined that the medical standards under which restraints and seclusion are – well, restraints specifically, are used in a medical setting are not yet established for the field of behavior analysis. And what I mean by this is that under health care, medical care, the Joint Commission has for quite a long time, actually, since 1988 is when these initially came out, has created criteria and requirements for the provision of restraints in a health care setting, meaning hospitals, but also to include like psychiatric settings, like partial hospitalization programs, which can be freestanding. And this is for organizations that are accredited under the Joint Commission. So the Joint Commission has very precise definitions of restraints which in the past have included even physically holding a beneficiary. That's a physical restraint. I noted just to see what updates are happening with Joint Commission. That Joint Commission in 2018 will be adding some language to differentiate physical restraints from physical holding of a child or youth. But that said, all of the criteria for using restraints in a health care setting under Joint Commission require that the setting be accredited by an accrediting body that comes in and reviews all of these standards, and that a licensed independent provider, meaning a physician or a nurse practitioner and in some states physician assistants, I did double check this, order the use of the restraints, that they do this in person. It can't be done by telehealth. That's prohibited today. And that they order it for a very discreet period of time which can be no longer than 24 hours. And that other allied health care extenders like LPNs and aids and certified aids and nursing staff are in the room and that they check the patient at very frequent intervals, like at one hour, and then every two hours to make sure that the patient is safe during the restraining process. And there is no such equivalent for ABA providers. They don't have physicians or nurse practitioners or PAs on staff. There's no nursing staff available, and even center-based care where this is offered is not accredited by an outside accrediting body that would come in and make sure that there are standardized policies and procedures in place to ensure the safety of the child. So I would just invite your field, if you want to pursue this to go ahead and see what's happening in terms of how this is involving in the health care arena, and perhaps consider establishing outside accreditation to ensure the safety of these kinds of procedures.

[Speaker 4] A few more points to make, one, please reference the description in the CPT assistant for those two codes, because they specifically say this is "to be provided to patients under the onsite direction of the physician or other qualified healthcare professional and require multiple technicians." That's a quote. They also go on to say that the codes are "often provided in an autism day treatment center, intensive outpatient program, or an inpatient facility." So I think they're speaking to some of those institutional requirements that you just discussed. Having said that, I recognize – I think we all here recognize that there is – and we said this before, that this – the use of the word restraint is a very broad definition when it comes to ABA services. And so I think what [Speaker 3] has encouraged

in the past and today is for the ABA community to better define the types of restraints and maybe classify them differently so that they may or may not be included. Because if you just hold someone's hands, that technically is a restraint, but that's not the same thing as holding them down or physically restraining movement.

[Speaker 3] Yes, and I think it's very interesting that Joint Commission is making this distinction in 2018. It's not all out yet, but an outline is out between types of mechanical restraints, physical restraints like appliances if you will versus physical holding of a child or youth, which seems to be more geared to the practice perhaps how ABA is using this. So I would look and see what's on the rise in terms of the requirements for health care settings. And I would more clearly, if I were interested in this and I were an ABA provider and a leader in your field, I would consider defining more precisely the types of restraints and the types of accreditation organizations that may be required for center based care to assure the safety of the use of this type of procedure. Thank you.

[Speaker 4] Okay, so the next CPT – question is about CPT codes as well. It's requiring providers to choose whether they are sole or tiered to prevent CTBs in the tiered model from delivering 0364T and 0365T at the BCBA rates. While it's unlikely, it is possible as sometimes BCBAs do need to take on that service, whether the tech is out or there are transportation issues. I'm not sure that we even in the TOM have put out that you must choose one or the other. I think in the last round table, maybe it was the one before, but we mentioned that they are not mutually exclusive. And essentially the tiered model, what that means is that technicians are involved in that model, not that the BCBAs are excluded from the model. So unlike the sole provider model where it is the exclusion of the technician, so we'll circle back with the regional contractors on that one, hopefully provide some needed clarification or guidance or there's an opportunity to better revise that in the TOM, we'll do that.

[Speaker 1] Thank you. [Speaker 3]?

[Speaker 3] Okay, and the next one is on the credentialing of BCBAs. And I think this speaks to that question, that the first questioner had for [Opening Speaker], and that is regarding our timelines of credentialing, and the question is if it is 120 days, how do we serve the family in a timely manner or without a gap in service? Now I do want to point out that there are industry standards, first, independent of TRICARE, across the United States for the credentialing process of providers. And the one commonly established organization that sets the industry standard is URAC, which is the Utilization Review Accreditation Commission, and the nationwide, industry-wide standard for credentialing is 180 days. Now we recognize that 180 days or six months is quite a long time to wait for credentialing, and we work closely with our regional contractors who periodically report their processing times, and our times are well within 120 days. We have found that typically that the regions report to us 30 to 45 days for processing a package for credentialing. Now of note, when we ask for more specific information about specific delays, the top three reasons that come back to us, because we do want this to happen as quickly as possible. I mean, I definitely hear your frustration. But I believe that 30 to 45 days is actually a quite a speedy credentialing process because credentialing requires primary source verification of licensure. And that can sometimes take time. We can't expect someone faxing in a copy of a license. We have to notify usually through the state, each state board, the primary source of license and have that

verified. So if that process can sometimes take time. Another reason for delays is that inconsistent information is sometimes noted on the application forms, because the application forms ask for very specific information, I think like your malpractice information is on there. And the third reason that the processing time can be delayed commonly is that each of the contractors have to go into the national databases to look for malpractice claims. And if there's any past history of that, that can delay the processing of a claim. So we try our past. Our averages are 30 to 45 days. We know there are outliers, and if there are any specific issues, contact your regional contractor and I'm sure they will be happy to work with you on facilitating that process. Thank you.

[Speaker 1] Okay, thanks, [Speaker 3]. There were a couple questions real quick about granting a provisional status to BCBAs and BTs. As you know, we have done that for BTs once they have their complete application in. They can start seeing patients while the final piece gets processed. We are not – we have not and do not plan to do that for BCBAs, the reason for that being that we treat BCBAs just like any other provider in TRICARE. And we do not have any other type of provider in TRICARE where we grant provisional status. You have to be fully credentialed before you see patients. That's also true in most of our – in our Military Treatment Facilities. I can tell you where I practice certainly it took me a while to get credentialed at Walter Reed, and I could not see patients until I was. So because of that and because we want to treat this just like we treat all other medical care, we intend to continue not to have a grace period for BCBAs. And with that I'm going to go onto licensure. And let me just talk briefly about licensure. The question here is: there are multiple states where licensure is required, but it's challenging to have licensure across different states because in each state you obviously have to pay for a separate license. The question was: could the original state of licensure cover any states that require licensure, and only make the home state a requirement? It's actually illegal for us to do that. Although it's true that if – as a military provider if I'm working at a Military Treatment Facility I can be licensed in any state I want, that's not true for TRICARE providers who are in the civilian community, regardless of what type of provider they are. So if you are required to have a license in a given state, then we have no control over that. That's even true for telehealth, for our telehealth providers we looked at trying to allow TRICARE providers who are doing telehealth to have one license, and we can't do it. Every state that you are working with patients in, you have to have a separate license. And again, those are state laws that we have no control over. So unless you're practicing at a Military Treatment Facility as an employee of that facility, you have to have a license for every state where the patient is located. Okay, and with that there was also a question about medical necessity criteria. Basically the question here was about contractor case management clinical decisions and providers getting information about medical necessity training specific to TRICARE, to the TOM Chapter 18, Section 18. And the concern here is that contractors interpret and apply this language to treatment plans, and could we host a medical necessity training webinar. Here's the challenge with that. We certainly are concerned about a lack of consistency, and that would be one benefit to the nationwide contract is I think that would help us get to that point of having consistency. But for the time being each regional contractor has some ability to use their own proprietary tools for determining medical necessity. So it may be slightly different between Humana and Health Net in T17. We're certainly working with them to minimize those differences to the greatest degree possible, but it would be difficult for us to do a webinar, again because some of the information they're using are proprietary, which means they won't share it publicly and they're not required to. But certainly if you send us

questions, we will answer them as best as we can, and we're happy to do that, so feel free to send us questions. If you have questions about medical necessity, and also certainly there is guidance in the TOM about that, which I would refer you back to as well. And with that I'm going to turn things over to [Speaker 4].

[Speaker 4] Sure, so the next topic came in about the outcome measures requirement. Essentially TRICARE is unlike any other funding source, consequently TRICARE providers encounter additional expenses to acquire this test instrument and paying staff to become proficient in administering assessments. The question is: to either reduce the number of required tests or reimburse providers for the cost of purchasing the assessments and training their employees to conduct the assessment. TRICARE cannot reimburse for the purchasing of testing material or the training of those materials. I think the point is, is that that's considered a practice expense or an administrative expense and that's prohibited in regulation and in our manuals. The manual references TRICARE Reimbursement Manual Chapter 1, Section 19, so that would fall under the category of, well, I guess the whole practice, the lights, the utilities, the pens, paper, pencils. That kind of stuff, and so that separately is not reimbursed, but that's also part of what the reimbursement code is for, and with this proposed creation for codes for BCBAs, that theoretically should help alleviate some of that financial piece. I think that's – oh, one more point I want to make is that the outcome measures in and of themselves we continue to get this comment. The outcome measure in and of itself is not a determinant of any one thing that it is a compilation of the entire program: so the treatment plans, the outcome measures, the physicians assessments, the parents' contribution, so I want to highlight that one if at all possible.

[Speaker 1] Okay, thank you, and can you talk, also, about the – who's going to identify which provider?

[Speaker 4] Pardon? There is one – I have another one to answer to – regarding there was a request submitted for permitting the parent guidance, so 0370T via telehealth, that the suggestion is that would have greatly helped with the access issues that are a concern. A couple of things, one, like I mentioned during the designated portion of the CPT codes is that the telemedicine policy has been revised, so now we have the opportunity to review how ABA could be impacted by that revision. But to reiterate what [Speaker 1] said is that across state lines that would not be a permitted practice due to state licensure, unless you have licenses in those states, so that would be the critical element there, but we did get your question. Now that the policy has changed, we can go back and look at if at all is that an option for our manual.

[Speaker 1] Thank you.

[Speaker 2] A question about the negotiating rates down, I think we already addressed that. We got that one.

[Speaker 1] Okay. Okay, good, so I think that – now there were a few questions we didn't get to because of time, but we will post answers to all of the questions on the Web.

[Speaker 4] Can I answer one more for the group?

[Speaker 1] Please do.

[Speaker 4] There was a question about group therapy, and I think this is a critical one to address. As those who have seen, maybe have seen the proposed draft of the exclusion section, paragraph 19 includes the definition of what group therapy, or an example of what group therapy is for the purposes of ABA services. We do not have a – well, there is a group code, but we are not reimbursing for that group ABA code. But the group is defined as one or two providers for more than two children, so you would have little Susie, little Johnny, little Mikey, and you would have [Speaker 1] as the provider, that would not be – that's group and that is not permitted. Also, what is not permitted is [Speaker 1] cannot bill for little Mikey, little Johnny, little Susie, as one on one. So I just wanted to make that distinction. The other thing is, if you have a one to one, and you happen to be around other people, I mean I think you're riding that line of what is considered group versus one on one. But if there are claims submitted for Doctor X with a patient, and Ms. X a different patient, then you can submit those one to one claims. Okay, that was the last one.

[Speaker 1] Okay, thank you. So I think we're going to start wrapping up here then. We've got about 10 minutes left, so again let me thank everyone on the call. I think we have something in excess of 180 people who RSVP'd this time, and we very much appreciate all of you taking time out of your very busy days and joining us for this. I know that that time is very valuable to you. So we really appreciate you taking the time, and I think I want to make a couple points here as we wrap up. First let me thank the team here, [Speaker 2], and [Speaker 3], and [Speaker 4], and [Speaker 5], and [Speaker 6]. They do great work in making sure that the Autism Care Demonstration continues to move forward, continues to provide outstanding care to our beneficiaries, and we would not be here without all their great work, so I just wanted to publicly thank all of them for that. They work long hours doing this, but we also want to thank you, because we know you all do very long hours taking care of the children and actually providing the ABA services, and that is also incredibly valuable to us. So thank you for that. We certainly recognize that based on what we've said today or even other issues, you may well have questions, and we encourage you to continue to submit those. As I mentioned there were one or two we weren't able to get to due to time, but we will post answers to all those questions and to any others that were submitted either during the session – I don't think we had very many of those, but if there are other questions we'll post those answers too. And we very much want your continuing feedback. We've made a number of changes to the Autism Care Demonstration based on the information and feedback for the Autism Care Demonstration that we received from all of you, that we received from patients and families. So that feedback is very, very important as we move forward and continue to try to improve the care that our children receive. So we welcome that feedback. Now I'll ask you to have something ready to write with. If you don't have our Web site, I'll give it to you, but it's really lengthy, so I'll give you a little bit of warning so you can write it down. A couple things, you're welcome to submit policy questions to that email address. We do ask that you use that email address rather than emailing any one of us directly. The reason for that is, not that we're trying to avoid you, but it's that that email, if you use our email box for the ACD, it goes to all of us at the same time. So if it's a question best suited say for [Speaker 2], he gets it, the same time if it's best suited for either [Speaker 3] or [Speaker 4] they get it, if it's something for me, we all see it at the same time, which means we'll get you the best answer faster if you use the mailbox. We certainly recognize there may be a number of questions coming right now, so we certainly try to get back to you very quickly. Occasionally we do have to do research. Again some of your questions are very thought provoking and very good, and it takes some time

for us to work through, but we get you answers as fast as we can. But what we would ask is that you not – you try to avoid using that mailbox for specific cases. A couple reasons for that. One is that that email is not secure. So we'd rather you did not send protected health information, specific patient information, that might identify someone, again because it's an unsecured email and there's some risk of privacy being violated if we do that. So we'd ask you not to do that. It's also, for example not too long ago somebody submitted an appeal request to the mailbox. The problem is that we're not the ones here that actually manage the appeals process specifically, so what we had to do with that was we then forwarded it to the people who do, but that led to a day or two delay in the appeal being considered. So please use the managed care support contractors. Use the appeals process that you have for the appeals, and send to the points of contact listed, in that material. Because, that'll make sure that it goes to the right person. And those things get considered as quickly as possible, and we get you an answer as quickly as possible. I think in summary what I'd like to say here is that we think the Autism Care Demonstration is one of the most robust autism benefits really anywhere. We've looked at pretty much all the civilian plans, and I think that some of the things that we have like no limits on hours and pretty much no limits on the cost of care, we spend about $250 million a year on autism care. What I will tell you, is that no one has come to me and told me, we're spending too much on autism care (i.e., you need to fix that, you need to spend less). What people have told me, senior leaders have told me is hey, we really appreciate the great work you're doing on autism, but you need to keep, like everything, we need to keep improving, make sure we're continuing to do the right thing for our military children and provide the care we need. And that is very much the focus not only of this group here, though I certainly think that's the focus of everyone in this room, but it's also the focus of our senior leadership as they have communicated to me on multiple occasions. As I said, we are working on improving; we are working on what comes next after this iteration of the autism demonstration ends next year. And given the time it takes for us to do contracting and make all the public notifications that are required, we're really already in the home stretch of deciding what we're going to do next, because it will probably take a full year to implement. So we're hoping to have decisions made here by early next year, early 2018. So that gives us the rest of 2018 to implement and make sure that our military children continue to get great care going forward into 2019 and beyond, so we very much need your input. We would appreciate your thoughts on what we should be doing with the Autism Care Demonstration going forward and providing care for these children. We're looking, as I said, at value-based care. A big piece of that is outcomes that are important to the patients and their families, that's a thing we're going to be looking at very actively over the next several months, so I certainly appreciate your input into that, and also as I say, we'll be reaching out directly to families to ask them that same question. So with that, let me look around the room here, anyone have any last thoughts? So okay, so then let me give you the email mailbox that I told you about, and really you, like I say, any policy questions, questions about what's covered, how do we handle things, questions about documentation, all those kinds of things are very appropriate for the mailbox. Please send us those. Certainly, if it's an individual care question, please go to your regional contractor contact first. And that's really the right place to go with those, but let me give you the email address. It's DHA.NCR.J-10.mbx.ACD@mail.mil, and I'll say it one more time because it is long. And we'll also put it in the minutes that come out that we'll post on the Web site, but again the email address is DHA.NCR.J-10.mbx.ACD@mail.mil and certainly also would encourage you to visit the Web site. We will post a transcript of this session there. We will post the questions and answers there. And also, the email address will be there.

And that is at www.tricare.mil/autism. Okay, so with that, again, thank you everyone for your participation today. We look forward to continuing to work with you. We anticipate having another one of these sessions early next year, early in 2018. And in the meantime, we'll certainly look forward to talking with you by email and other ways, and so with that we're going to end here, but say thank you again for your time. Have a great afternoon.

[Coordinator] This concludes today's presentation. Thank you for your participation. You may disconnect at this time.

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