Autism Care Demonstration – Provider Information Meeting #10

Questions & Answers

September 18, 2017

NOTE: These Q&As are informational ONLY and not enforceable changes. The next TOM revision will be the effective date for any approved changes.

TOM Policy

Question 1: The Basic Life Support (BLS), or Cardiopulmonary Resuscitation (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. This revision would allow providers who use center-based services to limit that training to full-time center employees, which will substantially reduce the cost of the requirement (including the cost of the course and the paid hourly wage for those hourly employees attending the training).

> Answer 1: BLS, or CRP equivalent, training is required for all Applied Behavior Analysis (ABA) providers. The regional contractors cannot track which providers are or are not providing center-based services, nor would it be reasonable to expect that the one person in the facility who would be trained in BLS, or CRP equivalent, would be present and/or available at the time of need. With the high frequency of co-morbid conditions such as gastro-intestinal or respiratory conditions, as well as the high frequency of the use of edibles and the subsequent risk of choking, the Defense Health Agency (DHA) is not willing to risk a beneficiary's safety for the cost of the training to the provider. However, DHA will modify the requirement to state, completion of the initial BLS training course must be done in person, but that subsequent trainings (recertification) may be online after the initial course.

Question 2: Currently behavior technicians (BTs) are required to be supervised for 5% of their direct hours per client, per month. The Behavior Analyst Certification Board (BACB) specifies that the 5% rule applies to a Registered BT's (RBT) entire caseload. This barrier is associated with longer wait times for vendors taking on new beneficiaries and results in requiring clarification given specific sets of circumstances. The question posed to the contractor was what we should do in the following scenarios:

a) the family cancels the session or multiple sessions, goes on vacation for multiple weeks, or in some way hinders the ability to meet that minimum;

b) a BT is sick or absent and a substitute BT is required to cover the case thereby resulting in the inability to forecast the number of initial codes utilized for direct services or overage in supervision percentage;

c) Clients that have only one session per month or lessened hours due to cancelations (due to 30 minutes being the minimum billable 0360T code) will once again go over the maximum amount of supervision.

Please let us know how to fulfill the requirement in the above situations.

Answer 2: DHA is aware of the discrepancy between the BACB requirement and the TRICARE supervision requirement. TRICARE's focus is on the quality of the care delivered by the BT (i.e., treatment fidelity) for every single beneficiary. If DHA reduced the requirement to align with the BACB, there is a potential that some cases would never receive BT supervision. Supervision of BT services provided to each patient is crucial to ensuring high quality care. DHA is not willing to potentially compromise the quality of a beneficiary's care, especially during this demonstration project where one of the goals are to assess how to administer the benefit in the future. Additionally, in light of the recent and on-going audits, this issue is a quality indicator that DHA is monitoring closely. Regarding the various scenarios, the supervision requirement does not change. However, it would be reasonable to engage directly with the regional contractor immediately regarding situations such as these to address the concern and find a resolution.

Question 3: Previous versions of the TRICARE Operations Manual (TOM) allowed for 100% of supervision of BTs to be completed remotely and is consistent with the BACB's requirements. However, the current TOM requires a minimum of one visit per month to be conducted in person (by the supervised assistant behavior analyst or authorized ABA supervisor). This requirement can provide barriers to beneficiaries who live in remote locations where there are few authorized ABA supervisors to supervise. Has DHA considered reverting back to this previous requirement and/or allowing this exception for beneficiaries who live in remote areas who cannot find other authorized ABA supervisors to supervise?

Answer 3: 100% remote BT supervision has never been permitted. In actuality, previous versions of the TOM required 100% of BTs supervision to be completed in-person. Partial remote supervision, where one of the two direct supervision sessions was allowed, was added in September 19, 2014 with change number 128. As noted above, supervision of BT services is crucial to ensuring safe, quality care, and this cannot be effectively accomplished without at least some of the supervision occurring in person.

Question 4: Will Tricare allow a "real" grace period for BTs to work with clients while completing BT credentialing? Staff are having to wait weeks post training to begin work. This causes significant delays in treatment, staff to quit because they aren't working, and families to become frustrated and give up. It can take a week to four weeks from the time a BT application is submitted until the BT can actually take the exam. BTs need to be allowed to start working with the client once their BT application is submitted. Other insurances we work with don't require BT certification at all.

Answer 4: TRICARE has made an accommodation to allow BTs who have completed all requirements for their credential (to include passing of the exam) to obtain temporary recognition as a TRICARE provider, for up to 90 days, to allow for the credentialing process

with the regional contractor. Prior to obtaining the certification, the BT is not held to any standard or requirements by any organization and DHA believes that the assurance of compliance with certification standards is in the best interest of the beneficiary. Therefore, no additional accommodations will be made for non-certified BTs. This is also consistent with the standard applied to other medical providers reimbursed by TRICARE.

Question 5: Requiring providers to choose whether they are “sole” or “tiered” prevents Board Certified Behavior Analysts (BCBAs) in the tiered model from billing for 0364T/0365T at the BCBA rate. While it is unlikely that BCBAs would routinely provide this service in a tiered model, it would be helpful to have the option to provide the service if a BT is unavailable due to illness, transportation issues, etc. A proposed solution would be to allow the ABA Supervisor to bill the 0364T/0365T codes at the higher rate regardless of whether the provider is enrolled as a sole or tiered provider.

Answer 5: DHA has not required that a provider must "choose" a model for the delivery of ABA services. However, the treatment plan must identify, and subsequently be approved, for tiered services. The definition of the tiered model is to include BTs, not exclude BCBAs. If a sole provider wants to add BTs, and therefore supervision, then a new treatment plan must be submitted and approved. A BCBA providing one-on-one services (via 0364T/0365T) in either tiered or sole delivery model should be reimbursed at the BCBA rate.

Question 6: How is group therapy defined?

Answer 6: In the context of ABA services, group therapy is defined as one or two providers delivering ABA services to multiple beneficiaries at the same time. Group therapy for ABA services is currently excluded from coverage under the Autism Care Demonstration (ACD). Providing one on one ABA services using the CPT code 0364T/0365T while in the same room where there are other one on one pairs working, is permitted. Also prohibited is billing for one on one services that are provided as group (one or two providers and multiple children). Claims cannot be submitted for a provider and beneficiary A, the same provider and beneficiary B, the same provider and beneficiary C, etc., for the same time period as one on one services.

Question 7: We have offices across multiple states where licensure is required for BCBAs in addition to the BCBA certification. We also utilize an approach where BCBAs support beneficiaries across multiple states due to access to care issues and supporting specific higher areas of need. This becomes difficult and costly for us to maintain the multiple licensure requirements for specific staff. A proposed solution, which is done for military medical doctors, could the original state of licensure cover any states that require licensure and just make licensure in the BCBA's "home state" meet the requirement? The BCBA would still need to be credentialed in each state but only licensed in one state. This would also support beneficiaries when they PCS to new areas and allows for us to better serve both in person and via telehealth in areas that may require licensure but cannot be utilized due to costs associated with licensure or lack of BCBAs in that location.

Answer 7: Purchased care providers are not afforded the same privilege of cross-state licensure practices as federal employees or military providers as the grounds for this exception are that the care is provided on federal property (i.e., Military Health System, Department of Veterans Affairs, Indian Health System, and Federal Prison System). For all purchased care providers, i.e., physicians, psychologists, dentists, BCBAs, etc., you must possess a valid license or credential, whichever is the higher required by the state, for each state in which you practice, meaning where the service is rendered, not the company's physical address. This is not a TRICARE requirement; this is a state law requirement. Additionally, if you are practicing in multiple TRICARE regions, you must be credentialed in all applicable regions. Regarding the use of telehealth, while only supervision of BTs is permitted at this time, the state licensure laws still apply, meaning you must possess a license in each state in which you are rendering a service. If you are physically located in Virginia and typically providing services in Virginia, and you are also supervising a case in North Dakota (both states require a license), you must possess a license for both states.

Question 8: A regional contractor has continued to deduct 5% from all payments to in-network providers. Given the bill passed stating reimbursement rates were to be returned to the rates prior to April 1, 2016, when will the 5% stop being deducted, and will providers be reimbursed for deductions taken this year?

Answer 8: DHA is aware that this practice was happening. DHA has taken steps to resolve the issue. DHA issued a letter informing the contractor to cease and desist this practice.

Question 9: In the draft TOM, Chapter 18, Section 18, paragraph 6.2.2. discusses reimbursement for assistant behavior analysts. Clarification is requested regarding if reimbursement is specific to the assistant behavior analyst supervision and not to the client's supervision; that is, an assistant behavior analyst can still bill the client as delegated by the BCBA without the BCBA being present as long as they are receiving their required supervision hours correct?

Answer 9: Paragraph 6.2.2 does not address BCaBA reimbursement. Rather it addresses the supervision requirements for assistant behavior analysts in that supervision of the assistant is reimbursable only when the beneficiary or parent is present, i.e., direct service. Indirect supervision is prohibited from reimbursement. Only the authorized ABA supervisor may submit claims for all ABA services; an assistant behavior analyst cannot independently bill for any service rendered. However the responsible BCBA can be reimbursed for care provided by a BCaBA (at the assistant rate) as long as the assistant is supervised and meets all requirements listed in paragraph 6.2.5.

Question 10: Now that there are multiple research studies that support the effectiveness for Parent Training via telehealth and given the fact that telehealth is approved to do supervision for BTs, allowing parent training to be done via telehealth would be an effective service delivery method. This would enhance the parent's ability to actively participate in session with their child, be taught behavior analytic protocols that should be generalizing with the family/caregivers, and allow greater access to care in areas that are too remote or that lack an adequate number of BCBAs. A proposed solution is to allow for at least one time per month Parent Training to be

billed via a "GT" modifier code for the 0370T (similar to the current GT modifier for the 0360/0361T code).

Answer 10: The telehealth policy has been updated (August 28, 2017) and DHA will review the modality of telehealth for parent/caregiver guidance for ABA services and propose a way forward for the next manual revision.

Question 11: Are the Pervasive Developmental Disabilities Behavior Inventory (PDDBI) and the Vineland Adaptive Behavior Scales, Third Edition (Vineland – 3) both required assessments for treatment planning for TRICARE?

Answer 11: Yes, both measures are required for treatment planning purposes.

Question 12: TRICARE requirements regarding outcome measures are unlike requirements of other funding sources. Consequently, TRICARE providers encounter additional expenses to acquire the test instruments and train staff to become proficient at administering the assessments. We are very concerned that the most recent draft TOM proposes an additional assessment requirement. A proposed solution is to reduce the number of required assessments; or alternatively, when applicable, reimburse the providers for the cost of purchasing the assessments and training their employees to conduct the assessments.

Answer 12: It is important to remember that TRICARE is not an insurance company. TRICARE is a medical benefit governed by statute and regulation which is unlike other funding sources which are able to more easily adjust premiums, deductibles, cost-shares, and benefit coverage. TRICARE does not have the legal authority to reimburse for the cost of purchasing an assessment tool. TRICARE does not reimburse for the cost of assessment tools or training for competency in using tools or materials for any provider. See the TRICARE Reimbursement Manual, Chapter 1, Section 19. It is also important to note that BCBAs are responsible for only the every six month PDDBI progress measurement. The addition of the Social Responsiveness Scale, Second Edition (SRS-2) and the removal of the Autism Diagnostic Observation Scale, Second Edition and cognitive measure was discussed in the March Round Table. As a point of clarification for the draft TOM, if approved, BCBAs will be eligible to be reimbursed for completing the Vineland – 3 and/or the SRS-2. This expansion of eligible providers allows, but does not require, the BCBA to purchase or administer these tests and therefore is not an additional expense to the provider or company if they chose not to participate in the option.

Question 13: In the draft TOM Chapter 18, Section 18, paragraph 8.2.4, it states that the "regional contractor shall identify which provider will complete and/or submit the Vineland-3 and SRS-2." Please provide clarification as to the intent of this language. We are concerned that the regional contractor may identify the wrong provider and that this would cause delays in patient access to care. Do not give the regional contractor the authority to identify which provider will complete the assessments; rather, standardize this process across all TRICARE beneficiaries.

Answer 13: The intent of this paragraph is to ensure that no duplication of services is provided. With the regional contractors managing the assignment of these assessments, through the use of an authorization, this management will reduce duplicative services as well as over-payment or no payment. DHA and the regional contractors are currently identifying a standardized process in order to minimize confusion and errors.

Question 14: We have no way to know when a Speech/Language Pathologist/Primary Care Manager/Neurologist might bill for assessment codes, etc. How would we know when someone else would be completing the assessment?

Answer 14: For the purpose of completing the outcome measures requirement in the ACD, DHA is currently developing a standard process for identification of which provider will complete this requirement. As stated at the Provider Information Session, no provider should take it upon themselves to complete the Vineland or the SRS-2 without notification from the regional contractor of such approval.

Question 15: TOM Chapter 18, Section 18, Paragraph 4.8 states, "previously diagnosed beneficiaries (those diagnosed prior to October 20, 2014) receiving ABA services for these disorders must have their diagnosis updated to conform to the DSM-5 criteria upon the next Periodic ABA Program Review per paragraph 8.4. This update of the diagnosis does not necessarily require a new diagnostic evaluation." The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) instructions and the federal Interagency Autism Coordinating Committee guidance are clear that individuals diagnosed with autism prior to October 20, 2014 retain their autism diagnosis and transitioning to the DSM-5 should not affect services. Please clarify what having their diagnosis "updated to conform with the DSM-5" criteria means and why it is necessary. If you are asking for providers to include a severity level with the diagnosis, this should be made clear instead of language regarding a diagnosis update to conform to DSM-5 criteria.

Answer 15: Conforming to the DSM-5 language is directed by the DSM-5 and does not interfere with ABA services. Symptom severity is required per the guidelines of the DSM-5. The DSM-5 does not recognize Pervasive Developmental Disabilities-Not Otherwise Specified or Asperger's Disorder as a separate diagnosis. Language in the DSM-5 states: "Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder." The intent is to ensure a consistent approach and to have all diagnoses conform to DSM-5 nomenclature.

Question 16: Will TRICARE implement a standardized form for proper medical documentation for ABA Session notes?

Answer 16: It is out of the scope for TRICARE to develop a standardized form for all ABA providers to complete as template for ABA session note documentation. TRICARE does not provide this service for any other medical benefit. The TRICARE Policy Manual, Chapter 1, Section 5.1, and TOM Chapter 18, Section 18, paragraph 16.0 provides the requirements for minimal documentation of a medical record.

Question 17: Per previous DHA instructions, *ONLY* the authorized BCBA was allowed to bill for services. *ALL* BCBA services were to be billed under the authorized ABA provider even if a different BCBA provided the service. Is this no longer the case? Am I correct that now each rendering BCBA should bill separately for services?

Answer 17: The authorized ABA supervisor is required to submit claims for every rendering provider. All services, including those services provided by other BCBAs, are to be billed under the authorized provider's authorization.

Current Procedural Terminology (CPT) Codes

Question 18: TRICARE does not use 0373T/0374T billing codes which allow a provider to bill a different rate when two BTs are required to protect the safety of the patient and/or treatment team. Regional contractors tend to believe that a child who temporarily requires two BTs should be hospitalized, but safety issues are often manageable outside of treatment and arise only during treatment. Therefore, hospitalization would not be clinically indicated and would be a less cost-effective treatment path. A proposed solution is to utilize the 0373T/0374T billing codes and ensure that the rate is higher than the 0364T/0365T rate to encompass the cost of two BTs.

Answer 18: The CPT Assistant (June, 2014) specifies that 0373T/0374T, Exposure Adaptive Treatment (conducted after the Exposure Behavioral Follow-Up Assessment), is "provided to patients under the onsite direction of the physician or other qualified health care professional and require multiple technicians." Additionally, the CPT Assistant states that these codes are often "provided in intensive outpatient, day treatment, or inpatient facilities."

The use of restraints are prohibited in TOM Chapter 18, Section 18, paragraph 19.0. The exclusion of these codes is based on the fact that there are generally no accepted standards governing when to use restraints as part of ABA services, type of restraints to be used, or generally accepted procedural requirements for the use of restraints during the provision of ABA services that conform with the concepts and requirements for the use of restraints in health care settings (hospitals, nursing homes, psychiatric facilities, intensive outpatient facilities, etc.).

TRICARE does not cover these codes because the field of Behavior Analysis has not yet evolved to develop requirements to protect beneficiaries from potential harm caused by restraint such as those required for beneficiaries in other settings (e.g., hospitals, residential treatment centers, intermediate care facilities for those with mental retardation, long term care facilities, etc.) under 42 Code of Federal Regulations (CFR) 482.13, Condition of Participation (for hospitals): Patient Rights, 42 CFR 483.358, Orders for the Use of Restraint and Seclusion (for Psychiatric Residential Treatment Centers and In-Patient Psychiatric units for children under age 21), and under 42 CFR Section 290ii The Children's Health Act of 2000. The use of restraints in the school setting is also regulated by several states as described in the U.S. Department of Education 2010 publication, Summary of Seclusion and Restraint Statues, Regulations, Policy and Guidance by State and Territory. Multiple statutes and regulations also exist governing the use of restraints in correctional facilities and other

types of facilities (detention facilities, programs for all-inclusive care for the elderly, etc.). Noticeably absent from statue and regulation is the use of restraint in ABA services.

The field of ABA must define the use of restraints in ABA service delivery as a health care procedure. Detailed procedural requirements and robust staff training in the application of restraint must be developed before TRICARE can consider coverage of these codes.

Question 19: Can 0370T be billed at the same time the child is receiving speech, Occupational Therapy (OT), Physical Therapy, or hospital services?

Answer 19: In this example, yes 0370T could be billed while the beneficiary is engaged in another service. This billing practice would be allowed because this code is focused on the parent/caregiver and does not require the beneficiary to be present.

Question 20: Can 0370T be billed concurrently with 0364T/0365T, i.e., the BCBA is providing guidance at the home with the parent, and the child is in clinic with a BT?

Answer 20: Yes, this specific scenario, of the BCBA working with the parent, and the BT working with the beneficiary, is permitted. However, claims documentation should clearly identify the rendering provider and time of the session.

Question 21: Can 0364T/0365T be billed when other companies are billing and providing nursing services? Child has 18 hour nursing care.

Answer 21: No, Services delivered directly to a beneficiary cannot be billed at the same time as another direct care service.

Question 22: TRICARE's definition of billing codes 0368T/0369T requires a parent or BT to be present. The CPT definition of the code does not require a parent or BT to be present. Clinically, it is useful to have a code that allows the ABA Supervisor to meet with the patient alone, as is the intent of this code. A proposed solution would be to modify the definition of 0368T/0369T to allow an ABA Supervisor to meet face-to-face with the patient alone.

Answer 22: As you are aware, TRICARE modified some of the codes to incorporate the variety of requests from the ABA provider community. The draft TOM includes a revision for this CPT code to permit "and/or" regarding the presence of the BT or parents. If this revision is approved, then the presence of the BT or parent will not be required.

Question 23: Can 0368T/0369T be billed for writing the discharge summary?

Answer 23: In general, documentation is included in the reimbursement for the direct service. Only billing for the assessment that results in a discharge summary is permitted.

Question 24: Do CPT codes 0368T/0369T include Coordination of Care meetings, such as with the BCBA, Speech Therapist, OT, and parent, with child present?

Answer 24: Coordination of care is not a reimbursable service as that is considered indirect care, even if the child is present, as this is not a service/treatment provided directly to the

child. Coordination of care is part of medical practice and would be expected as part comprehensive care.

Question 25: Which (if any) T codes can be potentially billed at the same time?

Answer 25: No CPT codes can be billed simultaneously, including T codes. That rule is a Center for Medicare and Medicare Services prohibition, not a TRICARE determination.

Question 26: On whom is it incumbent to know if the child is receiving other services? In case of review, are both billing parties subject to recoupment or just ABA services?

Answer 26: Every provider should be aware that another service is occurring at the same time. Both parties would be subject to review and recoupment should this type of claim submission occur.

Administrative

Question 27: Who can we speak to if the case manager is not returning our phone calls?

Answer 27: If you are not receiving a return phone call, please contact your customer service representative and ask to speak to the ACD program manager. If lack of return phone calls continues to be a problem, please contact DHA at dha.ncr.J-10.mbx.ACD@mail.mil or DHA.ACD@mail.mil.

Question 28: Is there a way we can communicate with TRICARE case manager's via email?

Answer 28: There are several different types of case managers under TRICARE. DHA will investigate the possibility of an email address along with specific guidelines for the purpose of an email address to the regional contractors under the ACD. Additionally, the regional contractors have phone numbers available for the ACD.

Question 29: How do we ensure the case managers have our correct fax and phone number and use it?

Answer 29: It is ultimately the responsibility of the provider to ensure that the contractor has the most up to date fax and phone numbers. DHA recommends reaching out to your contractor to confirm your contact information. There may be differences in who to contact if you are a network vs non-network provider. Please contact the regional contractor for further information.

Question 30: Is there a way that TRICARE regions could include approved authorizations in their portal for us to pull instead of waiting for the faxed authorization?

Answer 30: The regional contractors implement their best practices; this practice is not dictated by DHA. However, DHA will consult with the contractors to explore their options.

Question 31: What is the timeline for approving authorizations?

Answer 31: Authorization timelines depend on a variety of factors such as whether or not there are changes to be made to the treatment plan, medical necessity review, or completion

of the required documents. Please contact your regional contractor for assistance in obtaining authorizations.

Question 32: What is the timeline for credentialing contractors? If it is 120 days, how do we serve the family in a timely manner or without a gap in service? A proposed solution is to utilize a provisional status BCBAs until access to care issues diminish.

Answer 32: DHA assumes that the term "contractors" refers to ABA providers, specifically BCBAs. Industry standards, independent of TRICARE, across the United States for the credentialing process of providers is 180 days (see Utilization Review Accreditation Commission). DHA works closely with our regional contractors who report processing times are well within 120 days. DHA receives reports from the regions that processing a complete credentialing package averages between 30 and 45 days. DHA is aware that there are outliers to these numbers. DHA encourages the provider to contact their regional contractor to help facilitate this process. Please note that the primary reason for delays identified by the regional contractors is the submission of incomplete packages. Ensuring that all required documentation is submitted will help expedite the process.

With regards to a provisional BCBA status, DHA will not permit a provisional status for BCBAs as that provider category is being treated like any other independent provider category that is required to be licensed, fully qualified, and authorized under TRICARE to be reimbursed for services.

Question 33: There continues to be discrepancy between contractor case management clinical decision making on medical necessity determinations and providers for submitted treatment plans. Providers have not received any information on medical necessity scope training specific to TOM Chapter 18, Section 18, paragraph 8.3.3., nor have they received any information on how contractors interpret and apply this language to treatment plans. Can DHA host a Medical Necessity Training Webinar to outline the scope of what will be covered and how these determination are generally made?

Answer 33: The regional contractors provide various provider educations through webinars, mailings, and online information regularly, as well as engaging directly with providers specifically to answer questions regarding treatment plans, medical necessity criteria, and revisions to treatment plans. Each regional contractor uses their evidence based (proprietary tools) for medical necessity determinations. DHA does not dictate which criteria to use. Therefore, DHA cannot host a webinar for the purpose of defining medical necessity criteria. However, DHA has provided initial guidance in the TOM about what types of goals are and are not covered in a medical treatment plan.

Question 34: When, and if, will a switch be made to the new regional contractors?

Answer 34: As of January 1, 2018, Humana will be the East region contractor and Health Net will be the West region contractor.

Question 35: Will ABA coverage extend beyond 12/31/2018?

Answer 35: This decision is pending and will be announced via a Federal Register notice so all interested parties are informed.

Question 36: The regional contractor is placing BCBAs into direct conflict with the BACB Compliance Codes for 2.15 Abrupt Termination of Care when treating providers are given 14 days or less notice that a child's services will be completely terminated through the ACD. Can DHA, allow a full 30-day window after the determination is made to allow the parent/provider to appeal the decision or to at least prepare a transition plan?

Answer 36: TRICARE does not prohibit any provider from providing any type of services. However, TRICARE does determine what services will be reimbursed by TRICARE. Every authorized provider can continue to see the patient and continue any service they feel is appropriate, however, the provider will not be reimbursed for non-approved services. Therefore, the regional contractor is not placing providers in conflict with their ethical guidelines. Additionally, each regional contractor permits the submission of treatment plans in advance of the next authorization period. Please check with your regional contractor for the timeline of when they will accept new submissions of treatment plans for the subsequent authorization period. DHA recommends that every authorized provider complete and submit the beneficiary's treatment plan well in advance to avoid situations such as those listed in the question. Early submission also allows time for feedback/revising the treatment or allows for appropriate discharge planning. Ultimately, the responsibility to obtain an authorization or develop a discharge plan rests with the authorized provider.

Question 37: Will DHA allow services to stay in place during the appeals process?

Answer 37: This appeals question applies to all benefits that are being appealed, not just for ABA services. Currently, TRICARE does not permit services to continue during an active appeals process. However, current services are permitted until the current authorization expires. The denial applies to only the new authorization. Of note, the TRICARE Modernization Work Group, a group that looks at ways to improve the TRICARE benefit, is reviewing the appeals process and how to better managed this component. However, until such time, the current process remains in place.

For additional information regarding individual cases, medical necessity reviews, appeals, etc., please contact your regional contractor. For policy or program questions, please send an email to dha.acd@mail.mil or dha.ncr.J-10.mbx.acd@mail.mil