

**Autism Care Demonstration (ACD)  
Provider Information Meeting  
Questions and Answer  
April 26, 2018**

**Case management**

Question 1: Providers have not been informed of the organizational system used for Case Managers and how they are assigned clients and their authorizations. Can you please let us know who our Case Managers are so that we can know who's handling each case?

Response 1: Case managers are assigned to the beneficiary, not Applied Behavior Analysis (ABA) providers. Please have your family contact their regional contractor as the Defense Health Agency (DHA) does not have specific beneficiary information. The DHA continues to address the issue of case managers as part of the transition.

**CPT Codes**

Question 2: What is the reimbursement rate for T1023 and what date did that go into effect?"

Response 2: In TRICARE Operations Manual (TOM) Chapter 18, Section 4, paragraph 13.6, the language states that T1023 shall mirror the geographically adjusted reimbursement rate for the Current Procedural Terminology (CPT) code 96102. This is the CPT code for psychometric testing that was selected for the TOM because that code most closely mirrors the provider level and description of the activity in the code. The reimbursement rate by locality can be found at: <https://health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement/CMAC-Rates>. Then select "Procedure Pricing," then click "Accept," then in step 1, pick your location and step 2 enter 96102 under "Procedure Code," then click "Submit." A table will appear with several columns. Identify the current year, and the cell for Non-Physician/Non-Facility for the CHAMPUS Maximum Allowable Charge.

The effective date of the addition of T1023 was January 29, 2018. Any outcome measures completed before this date are not eligible for reimbursement.

Each six-month authorization will issue one unit of T1023 for the completion and submission of the Pervasive Developmental Disability Behavior Inventory (PDDBI). Any additional units of T1023 will be issued by the regional contractor for the specific use of completing the Vineland Adaptive Behavior Scale, Third Edition (Vineland-3) or Social Responsiveness Scale, Second Edition (SRS-2) when a specialty care provider is unable to complete those measures and a referral for outcome measures to a Board Certified Behavior Analyst (BCBA) is submitted. T1023 will not be reimbursed for the Vineland-3 or the SRS-2 without an authorization to a BCBA.

Question 3: Does each individual provider need their own initial code (i.e., 0364T) or should only one initial code be billed for each service per day per group?

Response 3: It is DHA's understanding that the regional contractors have their systems set so that for each of the paired codes, only one initial code can be used per day regardless if there are multiple sessions per day. DHA will review this issue for possible revision in the next manual update.

Question 4: We frequently need to make changes to the treatment plan (TP) multiple times between the six month assessment and TP updates. What codes can we use and how often can we use that? We consider this a requirement for quality of our programs.

Response 4: Modification to the TP should be occurring regularly throughout the six month period resulting in changes to the TP. CPT codes 0368T/0369T are the appropriate codes to use when making modifications to the TP. Every authorization should be requesting these codes. The frequency of the code usage depends on the beneficiary and the progress or lack of progress on the TP.

Question 5: Per the meeting January 2018, it was stated that billing under CPT Code 0368/9T, treatment modification for transition plans or discharge plans could be billed without the beneficiary present. However at this current meeting on April 26, 2018, it was stated that the beneficiary must be present for these plan updates. It was stated that the only service that can be billed under 0368/9 without the beneficiary present is the team meeting. Additionally, can a team meeting occur between only the Behavior Technician (BT) and the BCBA without the parent and beneficiary present? Please clarify this as it conflicting between the two provider meetings.

Response 5: As presented in the Provider Information Meeting on April 26, 2018, the following scenarios are permitted for reimbursement:

■ Conditions for use of 0368T/0369T:

Beneficiary present:

- BCBA works directly 1:1 with 1 beneficiary to develop a new or modified protocol
- BCBA demonstrates a new or modified protocol to a BT and/or parents/caregivers
- BCBA works with the family in developing a transition/discharge plan – TP update

Beneficiary not required to be present (although highly encouraged)

- BCBA leads treatment team meetings (with the parents/caregivers, the assistant behavior analysts, and/or BTs) to discuss the TP modifications

Question 6: For the CPT code 0370T, we have only received an authorization by Humana for 6 total units per 6 month authorization. This only allows for 1 unit per month. However, many clients who engage in severe behaviors require more parent trainings per month. Additionally,

clients working towards discharge require more parent training units in order to successfully transition services. Will this be changed so that we can request and have more than 1 unit per month authorized?

Response 6: As an expected part of the TP, parent/caregiver guidance to prepare for discharge is covered. The Medically Unlikely Edits (MUE), established by Centers for Medicare and Medicaid Services (CMS), permit up to one unit per day for CPT code 0370T. The regional contractor approves each CPT code based on medical/clinical necessity. Please contact your regional contractor regarding the number of units issued per authorization period.

Question 7: Do the regional contractors follow the daily unit restrictions for all of the CPT codes? The 60, 61, 64, 65, 68, 69, and 70?

Response 7: The regional contractors follow the MUEs, which are set by CMS, to help guide in determining medical/clinical necessity.

Question 8: How should the units be approved for authorizations? Is it a total number that can be used over the entire date range?

Response 8: At this time, the regional contractors each have their own way of managing the authorizations as the TOM does not dictate how the regional contractor should handle issuing of CPT code units. However, requests are typically submitted on a “per week” basis and that is how care should be rendered. Please note that “making up of hours” missed for whatever reason does not follow the concept of “medically necessary.” If 10 hours per week are requested, then 10 hours are to be rendered. “Making up hours” suggests that the difference is not “medically necessary.”

Question 9: Is TRICARE considering adding any additional CPT codes into the revision of the TOM.

Response 9: DHA continues to monitor the evidence regarding ABA CPT codes. No decision has been made regarding the inclusion of any additional codes at this time.

Question 10: Is TRICARE considering adding the CPT code for social skills group?

Response 10: Currently, the CPT code for social skills group is excluded from the TOM. DHA is currently reviewing this CPT code for possible inclusion.

Question 11: Are there plans to develop a range of social skills groups within TRICARE facilities?

Response 11: Generally, all ABA services continue to be a purchased care benefit. However, DHA is exploring how ABA services might be provided in an Military Treatment Facility (MTF).

## **Outcome measures**

Question 12: How old can outcome testing evaluations be for it to be valid? For example, within the two-year period.

Response 12: The Vineland-3 and the SRS-2 are required at baseline and then every two years thereafter. Ideally, these measures are obtained at the two year interval period to truly demonstrate 2 years of services.

Question 13: Is the Vineland required at the start of services or just after the first two years?

Response 13: The Vineland-3 is required at baseline (start of services) and every two years thereafter.

Question 14: I read in the TOM about the SRS-2 requirement after the teleconference. When does this requirement have to be implemented?

Response 14: The SRS-2 requirement was published December 29, 2017 and became effective January 29, 2018. All beneficiaries who reach their two year review on or after January 29, 2018 are required to have the SRS-2 submitted as part of the medical necessity review in order to be authorized for continued ABA services.

Question 15: Do we need to do the SRS-2 for the Vinelands we have submitted since 1.1.18?

Response 15: The SRS-2 is required as of January 29, 2018. The SRS-2 should be completed by the BCBA only if an authorization has been issued by the regional contractor. Please contact your regional contractor for any inquiries regarding the completion of the SRS-2 or Vineland-3.

Question 16: How do we find out when a client needs Vineland testing?

Response 16: Please contact your regional contractor for any questions regarding outcome measures and a beneficiary's timeline.

Question 17: Why do some clients require the Teacher PDDBI and some do not?

Response 17: All ACD participants are required to complete both the parent and the teacher form of the PDDBI for every six-month authorization period. The only exception is at baseline when the BCBA does not know the beneficiary well enough to complete the measure.

Question 18: Does the physician need to submit a referral for the assessment authorization?

Response 18: According to paragraph 8.1.1.2, the specialized ASD diagnosing provider completes the outcome measures. If the specialized ASD diagnosing provider cannot complete the measures in a timely manner, which is defined as at baseline or within the first year, then they are to submit a referral to the regional contractor to issue an authorization for an outcome measure to be completed by another appropriately trained TRICARE authorized provider where these measures are within their scope of practice. Eligible providers may include BCBAs. These outcome measures were selected in part as BCBAs may be qualified to complete these measures. Remember, do not complete neither the Vineland-3 nor the SRS-2 without an authorization as you will not get reimbursed without an authorization.

## **Regional Contractor Issues**

Question 19: Is there another way to contact WPS? Their voicemail says to call the basic Humana Customer Service line, but the reps can't answer my questions about if the paperwork sent to WPS for BTs to get into the billing system has been processed.

Response 19: All inquiries should be directed to your regional contractors as they are able to answer your question or direct you to the proper person who can answer your question. DHA is aware that during the transition, contacting WPS has been challenging and Humana Military (HM) representatives have not always been able to provide information in a timely manner. HM is actively working on improving customer service and has already made significant progress.

Question 20: The certification process with Humana for BCBA's and BTs has taken more than 10 days, and has been up to over 30 days. This significantly delays our ability to provide services to clients in a timely manner. What is the timeline for getting BCBA's and BTs Humana certified and how will this be regulated?

Response 20: In general, certification for all ABA provider types is completed within 7-10 business days. Credentialing of BCBA's under HM may take up to 30 days from receipt of a complete package. Please contact your regional contractor for an update on your application.

Question 21: What is the expected timeframe for a corrected claim?

Response 21: It is difficult to provide one response as each claim might have issues that require different efforts. Please contact your regional contractor for any assistance in resolving claims processing issues.

### **Misc.**

Question 22: We would like to know if clients are supposed to have multiple co-pays per day. For instance, if they see two BTs in one day, would they have separate co-payments for each?

Response 22: There should be only one co-pay per day for the same service. For example, if ABA services are delivered in multiple sessions per day, then there would be one copay per day for all ABA services. DHA is aware that beneficiaries were being billed multiple copays per day for the same type of service, but this has since been resolved.

Question 23: Are Individualized Education Programs (IEPs) required?

Response 23: The current language in the TOM is that IEPs are required only if the TP is specifically requesting TRICARE-reimbursed ABA services in the school setting. The IEP is required if authorization for in-school TRICARE reimbursed ABA services be requested. Additionally, reviewing the IEP is good practice to ensure proper coordination of services regardless of whether or not ABA services in the school setting are being requested. The authorized ABA supervisor will then have more information about the child's functioning from multiple sources of information.

Question 24: Does the physician need to submit a new referral every two years?

Response 24: Yes. The authorization cannot be renewed after two years of ABA services without a new referral from the Primary Care Manager (PCM) or the specialized ASD-diagnosing provider. Please remind your families to make their two year appointments in a timely manner.

Question 25: Can a Board Certified assistant Behavior Analyst (BCaBA) be a supervisor on a case?

Response 25: No. A BCaBA cannot supervise a case independently under TRICARE. That is in accordance with the credentialing bodies' requirements. Assistant behavior analysts can assist the BCBA, but they cannot supervise a case independently. That responsibility must be delegated by the BCBA.

Question 26: Is there a plan to include Telehealth/remote services for CPT codes 0370 and 0368/9 under the "GT" modifier. Allowing remote work to be done for TP updates and team meetings would open up a wider range of services to clients as well as more frequent updates as needed. Additionally, allowing for parent trainings to be conducted remotely allows for training additional caregivers and can increase parent participation as it is more easily accessible.

Response 26: Currently, only supervision is eligible for telehealth capabilities. DHA is currently looking into the possibility of telehealth for parent guidance. However, no changes have been approved at this time. Please see future TOM revisions regarding any changes to the benefit.

Question 27: We keep graphs in our internal electronic health record, but are they required on the document submitted for TP reviews?

Response 27: Any documentation that you have collected should be submitted with the corresponding request. Graphs may be submitted with the TP, especially when specifically referencing a graph. Session-to-session graphs or data are not necessary when submitting the TP. However, a summary graph may be more appropriate.

Question 28: Can parents pay out of pocket for social skills groups as it is not a currently provided service of their insurance?

Response 28: Social skills group is not a covered benefit currently under TRICARE. Parents can elect to obtain non-covered services independently.

Question 29: Is there someone within TRICARE that I can direct parents to that can discuss choices and offerings to support social skills development for their children outside of the ACD?

Response 29: Since social skills groups are not a reimbursable service under the TOM, the regional contractors are not able to offer any comments regarding placement. However, the regional contractor may be able to provide resources for group psychotherapy as appropriate. Please contact your regional contractor for additional questions.

Question 30: Is BT Supervision required?

Response 30: TRICARE requires that all BTs must be supervised at least 5% of their direct service time during a 30-day period for every child.

Question 31: So it sounds like the ABA program will not be ending, what are the changes in 2019?

Response 31: Any changes to the ACD will be published with subsequent manual revisions. No changes for 2019 have been reviewed or approved at this time. DHA will provide communication when the manual changes will be available.

Question 32: Do you know when the rates will be published?

Response 32: Reimbursement rates effective May 1, 2018 have been published and are available at <https://www.health.mil/autism>.

Question 33: What are the required documents for submitting a TP at the every six month mark?

Response 33: For continued authorization, the contractor should receive the updated TP, the PDDBI, and whatever other graphs, charts, and information you are updating. Additionally, if it has been two years since the Vineland-3 and SRS-2 have been completed, these must also be submitted with the two-year TP update.

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