Autism Care Demonstration – Policy Changes

Questions & Answers – Set 5 (published 7/30/2021)

NOTE: These Q&As are follow up responses to questions submitted regarding the ACD policy changes published 3/23/2021. These Q&As are for informational purposes only.

CPT Codes – General

204. Is telehealth acceptable for all CPT codes until the pandemic is over?

Response: Only CPT Code 97156 was permitted via TH during the pandemic. No other Adaptive Behavior Services (ABS) Current Procedural Terminology (CPT) codes, except T1023, should have been rendered via TH, and then subsequently billed to TRICARE.

205. Are the assistants no longer able to bill for assessments/intakes/treatment plans?

Response: Assistant have not been able to submit claims independently since the beginning of the ACD. This is not a change. However, assistants may be eligible to render certain CPT codes, while the supervising BCBA files the claim. Although the BCBA files the claim, the assistant, if the actual rendering provider, must be identified on the claim.

206. During the 4/16/21 webinar, the speakers discussed how some of the definitions are related to the AMA, but other definitions are not aligned with the AMA. How does the DHA make the determination of when and how to follow AMA and CPT coding guidelines?

Response: The American Medical Association (AMA) defines procedure codes for the purpose of reimbursement. The CPT coding assistant guidelines are not authored by the AMA but rather the ABA coding coalition. As a reminder, ABA services are authorized under the demonstration authority.

207. Can you describe which codes the assistant can render?

Response: Please review the language in TOM Chapter 18, Section 4, paragraph 8.11.6.2 for all CPT codes and their provisions/requirements.

Concurrent billing

208. Can ABA providers bill for any and all combinations of the new CPT codes with current CPT codes on the same day as long as they are not concurrent?

Response: Yes. Any and all ABS CPT codes could theoretically be rendered on the same day but the presence or absence of the patient would limit specific combinations. However, if there is any overlap in certain codes, that is considered concurrent billing and therefore,

only the higher of the rendered CPT code will be reimbursed. As with all CPT codes, assistants and behavior technicians (BTs) cannot bill for any service. Assistants and BTs may render services, but cannot bill. The claims should identify the billing provider as well as the rendering provider.

209. With the new restriction of concurrent billing, how can a child with ASD have a BCBA present during an ST appointment?

Response: Concurrent billing in this question has always been prohibited. This is not a change.

210. Can you bill 97151 and 97153 at the same time?

Response: Potentially yes, so long as the beneficiary is not present during both encounters. See concurrent billing chart at paragraph 8.11.7.3.8.

211. Currently we bill 97155 and 97153 concurrently, but after 8/1, we will no longer be able to bill for these concurrently?

Response: Concurrently billing of 97155 and 97153 has always been prohibited. If you have been engaging in this practice and have received payment, please know that these claims are subject to recoupment.

212. After 8/1, can we bill 97153 and 97155 concurrently?

Response: No.

213. If 97155 is being provided and it is necessary that a BT is to be called in for aggressive behavior, why is it that these can't be billed together?

Response: Concurrent billing, as well as the use of restraints has always been prohibited.

214. What are the reasons for not following the AMA guidelines for concurrent billing on 97155 and 97153 as outlined in the AMA CPT Assistant article?

Response: The AMA develops CPT codes for the purpose of reimbursement of a procedure. The AMA does not dictate how codes are to be authorized and reimbursed under a funding source.

215. Can 97156 be billed while the client is getting 97153?

Response: Yes, so long as the parent session does not include the child's session.

216. Can 97155 and 97156 be billed concurrently when 2 BCBAs are billing for the same client?

Response: Yes. When 2 providers are rendering CPT codes 97156 and 97155 at the same time, CPT code 97156 must not include the beneficiary. CPT Code 97155 requires that the beneficiary is present for the direct service. CPT Code 97156 requires that the parent/caregiver is present, but the child is not required.

CPT Code T1023

217. Will all current authorizations be honored through their expiration date and all future authorizations after 8/1/21 fall under the ACD changes?

Response: Yes, for the CPT code changes, that is correct.

218. When the physician referral requirement for T1023 is no longer required as of 5/1/21, will ABA providers still need to obtain an authorization or is this something that will not require an authorization?

Response: Yes, prior authorization for all care rendered by ABA providers is still required.

219. With the removal of CPT Code T1023, does this mean that we will no longer be required to complete the PDDBI?

Response: No. Completion of the PDDBI is still required. Authorizations on or after 8/1 for the PDDBI will be covered under 97151.

220. Can you clarify why T1023 is being removed while the requirements for the PDDBI is still in place?

Response: T1023 is a non-standard usage code that was used to reimburse for outcome measures. With the alignment of outcomes to 97151, it is reasonable that this reimbursement also align to that code.

221. How many units of CPT code 97151 are allowed for what T1023 used to be?

Response: One unit of CPT code 97151 is issued for each outcome measure per occurrence.

Medical Team Conference (MTC)

222. Are MTCs required?

Response: No. MTCs are not required, but are a mechanism for reimbursement for treating providers to meet with the other member of the team to collaborate and problem solve treatment challenges.

223. Who is responsible for coordinating/scheduling MTCs?

Response: Any one of the treating providers can initiate an MTC. However, according to paragraph 6.3.1.2, if an Autism Services Navigator (ASN) if assigned, the ASN must coordinate and participate.

224. How long is a unit of 99366/99368?

Response: Each unit is approximately 30 minutes in duration. See paragraph 8.11.6.2.7 for additional information.

225. What if there are only two professionals that work with the beneficiary?

Response: If there are only two treating providers, then the CPT code is not eligible per the terms of the code.

226. Would a BCBA in a school setting and a BCBA authorized under TRICARE qualify as two different specialties?

Response: No. The BCBA in the school setting is neither TRICARE authorized nor subject to providing clinical care in accordance with the ACD. Additionally, if they were TRICARE authorized, this would be considered as 2 providers of the same specialty, so that would also be prohibited.

227. Are all medical professionals authorized as TRICARE providers aware of this new requirement with the ACD to attend MTCs and the requirement for documentation?

Response: Participation in the MTC is not a requirement of the ACD. It is a mechanism for reimbursement for those providers who choose to collaborate with a beneficiary's treatment. Continued education will be provided to providers regarding this CPT code. Medical Team Conferences are not new as they are utilized by TRICARE providers under the Basic Benefit. However, the inclusion of ABA providers to attend and receive reimbursement is new.

228. Should parents always be included in this MTC?

Response: Parents are not required to attend CPT code 99368 (MTC without patient by health care professional). However, the beneficiary (or parent) is required to participate in 99366 (MTC with patient and/or family).

229. Do school district SLPs/OTs qualify as qualified health care provider (QHPs)?

Response: No. These are not TRICARE authorized providers and they are not rendering a clinical treatment plan.

230. Can the MTC codes be used for individualize Education Program (IEP) meetings?

Response: No. An IEP meeting is not a clinical meeting.

231. Do all QHPs (SLP/OT/PT/etc.) bill 99366/99368 for the MTCs?

Response: All participating providers in the MTC (one provider per specialty) should bill for their time if all minimum requirements are met for the CPT code.

232. For beneficiaries who do not have an ASN, can these codes still be billed?

Response: Yes.

233. Where do I enter the special processing code when submitting claims for MTCs?

Response: Please contact your contractor or visit your contractor's website for this information.

234. How can we be audited for MTC when this code is note required?

Response: The audit is completed for providers who use this code, not for providers who do not participate in this meeting.

CPT Code 97151

235. We are under the understanding that under the new regulations, we need to bill our units for the 97151 code within 14 days of authorization approval. Typically, after a client is already in services, these units are used during the reassessment period for the next reauthorization. With the new changes, how do we correctly bill for assessments used to complete the reauthorization reports and interviews? When approved for the 97151 code, will we be backdated for the assessments completed in order to request that code?

Response: For clarification, it is not that you need to bill for the units of 97151 within 14 days of the authorization approval, rather that you have a 14-day period to complete the assessments or reassessments. The 14 day window starts from the first claim filed for the date of service (DOS) to the last claim filed for the DOS, not from the date of authorization approval. This is not a new change in this policy update. If you have units of 97151 authorized in your existing treatment authorization, then those codes are for the purpose of the reassessment and TP update which should be conducted in preparation for the next authorization. Please contact your contractor for additional questions regarding your authorization.

236. Are we expected to do all of that assessment work in the 14 day window given?

Response: Assessments and reassessments for the purpose of TP development and update are expected to be completed in the 14 day period. This is not a new change in this policy update.

237. Can 97151 be billed by multiple providers?

Response: CPT Code 97151 may be rendered by the authorized ABA supervisor or the assistant. However, the billing provider can only be the authorized ABA supervisor. Of note, the claim must reflect the actual rendering provider, i.e., the assistant behavior analyst.

238. Do you accept Assessment of Functional Living Skills (AFLS) as a stand-alone assessment for an ABA authorization? What other stand-alone assessments do you accept other than the VB-MAPP and ABLLS-R if any?

Response: The BCBA may use any tool for their assessments. The only required tool from the BCBA on a six month interval is the PDDBI.

239. Should an initial or reassessment be billed as used (across several days) or should we structure the assessment to occur on a single day in order to be billed all at one time?

Response: All claims filed should be reported as used. Otherwise, you are improperly filing claims.

240. Since the referring providers are the ones who request the initial intake/assessment, are the providers going to be aware to ask for more units for 97151 instead of the standard amount of 16 units?

Response: Referring providers, such as the Primary Care Managers (PCMs) or specialty diagnosing providers, do not request any ABA CPT codes or their units. This is the responsibility of the authorized ABA supervisor.

241. Please provide clarification on whether or not parents/patients must be present during reporting writing?

Response: CPT code 97151 allows for the indirect service of report writing. The term "indirect" means that the beneficiary/family does not need to be present.

242. For authorizations that are due 8/1 (submitted by 7/1), will we be allowed the 6 hours of 97151 if we are filling out prior to 8/1?

Response: No. These change are not effective until 8/1/21.

243. Is there still the limitation that 97151 units cannot be billed sooner than 6 months since the last usage?

Response: The purpose of 97151 in the current authorization is for the reassessment and TP update for the next authorization. These units should be rendered in the appropriate time to evaluate and make determinations for that next treatment plan.

244. Can 97151 be billed under the assistant if the work is delegated to the assistant?

Response: The authorized ABA supervisor is the only one allowed to bill for services. However, the assistant may render 97151. Both the rendering provider and billing provider should be listed on the claim.

245. We have historically received 32 units of 97151 to meet all of the requirements of TRICARE's 6 month treatment plan. It actually takes us longer than 8 hours to complete these reports. What type of review has been done of the use of 97151 and the number of hours necessary to complete all of TRICARE's requirements? It is disconcerting to see the amount of work required every 6 months by TRICARE has increased (yet another assessment to coordinate and review) while the amount of time allocated to complete all of the work has decreased (from 32 to 24 units…with maybe 1 more unit to review the new assessment).

Response: This policy change increases the number of units from 16 to 32 for the initial assessment and from 16 to 24 for follow up assessments.

246. Are providers expected to ask for a separate authorization for units for 97151 to complete the outcome measures? If not, are they bundled into the code starting 8/1? If they are bundled, am I correct that the expectation is to complete the outcome measures first, submit them, then update the TP and submit that after for a concurrent authorization request?

Response: Only the PDDBI is automatically authorized. All other outcome measures must be prior authorized. If you would like to complete these measure, contact your contractor and let them know of your ability and availability.

247. 97151 may not be conducted via TH. This would now include outcome measures. Is this correct? The majority of our patients currently completing outcome measures by TH because their ABA providers do not offer these assessments.

Response: The administration of the outcome measures, typically the parent form for each measure, is considered an indirect effort since the provider is not required to be present. Indirect activities may be billed under CPT 97151. However, the authorized provider should be available for questions and provide clarifications as appropriate.

248. With T1023 being deleted after 8/1 and 97151 absorbing that code for all outcome measure, will DHA consider an increase to the amount reimbursed for 97151 since T1023 reimburses at a higher rate per unit vs per unit reimbursement of 97151? Particularly with additional measures being require, this is a pay cut for providers.

Response: No. The reimbursement rate will not be adjusted for this code.

249. If outcome measures are part of 97151, how do you know who is doing the other ones?

Response: The only outcome measure required of the BCBA is the PDDBI. All other outcome measures will be prior authorized to the identified provider. Do not complete the measure if you are not authorized.

250. Will units of 97151 for outcome measures need to be billed in the two week time required for assessment?

Response: The PDDBI will be required in conjunction with the 14-day period. If you are authorized to render other outcome measures, those should be completed in the respective time period for the next authorization.

251. Can you clarify what "prior authorized" means with the outcome measures for 97151?

Response: Prior authorized means that you cannot receive reimbursement for a code unless you have been given permission to do so via notification through an authorization.

252. With T1023 going away, will all outcome measures be a part of 97151?

Response: The PDDBI will be rendered under CPT Code 97151. Should a BCBA be authorized to render the other outcome measures, they will be issued one additional unit of 97151 per measure.

CPT Code 97155

253. What if you don't need 97155 monthly because you do and adequate assessment and planning to begin with?

Response: All care for any treatment plan should be periodically monitored and possibly adjusted. ABA services are not an exception.

254. What if we are a sole provider practice, do we still need to do 97155?

Response: Yes. It is unclear how you are monitoring and updating the treatment plan during the 6-month authorization period otherwise. Do not use the time you are rendering another code to account for the activities that should be rendered under CPT code 97155.

255. Does a BCBA need to do 97155 once per month for every client or can this be delegated to an assistant who is the case supervisor?

Response: The authorized ABA supervisor must complete at least one session of 97155 per month per beneficiary as they are the responsible provider for the case. The assistant may render other sessions, but the assigned supervisor must oversee the case, and make direct visit at least once per month.

256. Can any authorized BCBA provide CPT code 97155 or does it have to be the overseeing BCBA?

Response: In the team approach, any BCBA on the team may render CPT code 97155.

257. Must the beneficiary be present when rendering 97155?

Response: Yes. The beneficiary is required to be present with this code.

258. When is the start date for the penalty of 97155?

Response: All CPT code changes become effective 8/1/21.

259. Can 97155 be used for BT supervision? If not, what code is used for the supervisor to be compensated for supervising the BT in sessions?

Response: No. TRICARE does not reimburse for BT supervision. This change occurred January 1, 2019.

260. What locations are billable for 97155?

Response: Appropriate locations for rendering CPT code 97155 are the home or clinic.

261. What if something new comes up and we need to do additional assessment outside of the 14-day period?

Response: The appropriate code for these periodic assessments is CPT code 97155.

262. What is the minimum amount of 97155 that is required per month?

Response: All CPT codes should be rendered per the clinical necessity. That number is individualized and beneficiary specific. However, please remember that the authorized ABA supervisor must complete at least one session of 97155 per month per beneficiary.

263. Can goals be added to a treatment plan using the monthly 97155?

Response: While it's plausible that goals may improve dramatically and would warrant a change, the 6-month authorization period should identify appropriate goals for that level of progress or lack thereof.

264. Why has TRICARE made a medical predetermination that 2 hours of 97155 is the maximum needed for the day, especially when this violates the MUEs established by the AMA?

Response: The utilization of 8 units per day is not new in this policy change. Additionally, the AMA does not set the MUEs. Rather, CMS establishes MUEs for the purpose of being indicators of potential fraud.

265. Can 97155 be billed via telehealth?

Response: No. CPT code 97155 is not eligible for rendering via TH.

266. The TOM adds a requirement for 97155 to be completed at least one time per month. We do not disagree with this requirement. Does DHA intend the requirement be fulfilled by billing one meeting per calendar month or six meetings within a six-month period?

Response: This requirement is that that authorized ABA supervisor complete at least one session per calendar month.

267. How does DHA intend to account for instances outside of the provider's control (i.e., family pauses services, beneficiaries becomes sick, family goes on vacation, natural disaster, parental cancellation)?

Response: For situations where no ABA services are rendered in any given month, please connect with your regional contractor for next steps to ensure the penalty is not applied.

268. What should a session note look like if Behavioral Skills Training was used to update a program of BIP, rather than training a BT?

Response: Training of a BT is not a reimbursable service under any CPT code under the ACD. Please see paragraph 8.7.2 for progress note documentation requirements.

269. In the case of a divorced family where the child spends 2 months of the summer with the other parent, what would we have to do in relation to documentation to ensure services aren't terminated per the monthly 97155 requirement?

Response: If there is a pause in 1:1 services outside of the provider's control, then please connect with your regional contractor regarding next steps to ensure continuity of care and proper claims payment.

270. Does the supervising BCBA have to see the client where the assistant is the lead?

Response: All cases must have a supervising BCBA as the lead of the case. Assistants are not permitted to independently lead any beneficiary program.

271. How does DHA justify the exclusion of concurrent billing for 97155 and 97151 when they are different services provided by different provider types (assistant and BCBA)? This seems to be an MHPAEA violation.

Response: The purposes of the codes are both related to assessing and updating the treatment plan. Regardless of who is rendering what, the activity of assessment is duplicative and therefore considered concurrent.

CPT Code 97156

272. Could you clarify the removal of the assistant behavior analyst to bill for 97156? The TOM changes state is may be delegated to an assistant, but only the ABA supervisor may bill for it. Does this mean that the supervisor should bill when the assistant renders this services or when the assistant renders 97156 it is not billable?

Response: As with all CPT codes, assistants cannot bill for any service. Assistants may render services, but they cannot bill. The claims should identify the billing provider as well as the rendering provider.

273. Does the assistant time rendering 97156 count towards meeting the 6 times minimum per 6 months?

Response: Yes.

274. Is there a minimum duration for each of the 6 required parent training sessions? We will usually schedule those for an hour, but if a parent can only come for 15 minutes, will that suffice?

Response: All rendered ABA services should be clinically necessary and appropriate. The duration is based on the individual case.

275. When it says "during the first 6-month authorization," does that mean the first time that client has ever received ABA or regardless for any new intake with a company, no TH for parent training is allowed within the first authorization period?

Response: When a provider is assigned a new beneficiary, the requirement applies to the first 6-month authorization period.

276. During the parent training meetings, can the parents demonstrate ABA techniques with their child as part of the behavior skills training?

Response: Beneficiaries are encouraged to be present during these parent training sessions while the authorized ABA supervisor is working on the parent training goals and practicing them with the beneficiary.

277. If 97153 will not be covered in the community settings, will 97156 be covered so that parents/caregivers can be trained on how to manage the beneficiary's behaviors in these community setting?

Response: Per paragraph 8.11.6.2.3.6, the only eligible settings for CPT code 97156 is the home or clinic setting.

278. For parents of 2 children with ASD receiving ABA services through TRICARE, are 6 sessions still sufficient for the family or do they need 6 parent trainings per child?

Response: The requirement is per child. No two treatment plans are the same, therefore, the parent will need time dedicated for each child.

279. How do we manage the parent training requirements with adult clients?

Response: If there is a responsible guardian, regardless of age, it is expected that the authorized ABA supervisor engage that adult.

280. Why are we not allowed to bill 97156 via TH until after the first 6 month authorization?

Response: Establishing a strong parent training program requires direct interaction with the family to create effective and ample opportunities to model behavior principals and provide feedback.

281. What documentation is required to show parents are not available or don't show up for the family treatment guidance? Is both parents working a valid excuse for not attending?

Response: Both parents working is not a reason for no parental participation. The ABA provider still leaves the family at the end of the session, and the parents need the skills to maintain and generalize progress outside of the session time.

282. How is the limitation of a location of services for 97156 not a violation of mental health parity?

Response: The purpose of the ACD is to render clinically necessary and appropriate services for the core symptoms of ASD. The ABA provider is not actively rendering ABA services outside the home and clinic setting as permitted under the ACD.

283. Given that we work with military families, some parents may be out of the country but still want to participate in parent training. Will TRICARE consider permitting TH for parent training so families aren't penalized?

Response: Yes, TRICARE now permits TH for parent training. However, scope of licensure practice, and state or country laws still apply. Please contact your contractor for additional guidance on rendering parent training.

284. Since TH will be allowed for 97156 after the first 6 months, will providers be able to concurrently bill 97156 TH with 97153?

Response: Yes, so long as two different providers are rending two different sessions. See paragraph 8.11.7.3.8 for additional information.

285. Can you please clarify if we're allowed to do 97156 via TH for the first 6 months through the pandemic period and the requirement for face-to-face will only apply once that period is

over or if this is the case period and we'd lose the authorization if we provide that services via TH at our own expense?

Response: The COVID exception to policy provision has been end-dated. Effective 8/1, the CPT coding guidance in the TOM is available. Therefore, the first six months of in person training for new beneficiaries applies.

286. I see the maximum allowance for CPT code 97156, but what is the minimum length of time for each session?

Response: All care should be clinically necessary and appropriate. Those determinations are made on an individual basis. The 97156 CPT code is in 15-minute increments.

CPT Code 97157/97158

287. How do we align the 97157 with our organization's policy of appropriate social distancing group parent training via TH?

Response: Per paragraph 8.11.6.2.5.5, CPT Code 97157 is not authorized to be rendered via TH.

288. Why is 97156 covered via TH, but 97157 is not?

Response: CPT Code 97156 is rendered on an individual basis whereas 97157 is a group session.

289. If group parent trainings occur, does this require a separate treatment plan with goals specific to the parent group, or is this more intended for families who have children who are working toward similar goals, and that parent goals are similar for all families?

Response: Participants in any group setting should have similar goals for that cohort. Parent goals should be incorporated into each beneficiary's individual treatment plan.

290. Is code 97158 only to be used by the BCBA?

Response: DHA will provide clarification in the TOM that assistants may be delegated this rendering as appropriate.

291. Is code 97158 to be used both for the time the BCBA is running the group treatment and probing that group treatment goals are being met?

Response: CPT 97158 is used when the authorized ABA supervisor, or delegated assistant, is running the group. Adjustments to the treatment techniques may be made during the group session as needed.

292. Is 97158 more of a transition out of therapy code? Can it threaten therapy?

Response: CPT Code 97158 should be used when clinically appropriate. However, as skills develop, it would be expected that services would be working towards discharge. So while

group services should naturally lead to a transition out of ABA services, they will not "threaten" services.

293. Given that one of the characteristics of ASD is limited or lack of social skills, can we add a group code?

Response: CPT code 97158 was added in the policy change effective 8/1/21. New authorizations after this date may request this code pending clinical necessity.

294. How much does 97157/97158 pay?

Response: Please see the reimbursement rates posted on www.heatlh.mil/autism.

295. What are they typical units requested for 97157/95178?

Response: Recommended units should be based on the individual child, not "typical units requested."

296. If we do not have a clinic setting, can we still do group trainings if we find another private space to work out of, i.e. rent a room out of an office, reserve a large private room at the library?

Response: If the ACSP can create a group environment that meets all requirements for HIPPA/Privacy and deliver ABA services consistent with the TOM, this would be permitted. Please contact your regional contractor for guidance on claims filing.

297. Codes 97157/97158 has been in place since 2019. Why is TRICARE waiting until 8/1/21 to make these services available?

Response: These two codes were not authorized under the ACD prior to this policy update.

Clinical Necessity Reviews

298. What criteria will be used to determine progress?

Response: Please see paragraph 9.1 for a description of the utilization management requirements for the contractors.

299. Is the clinical necessity review done by the contractor or is it more like a peer review between the contractor and the provider?

Response: Per paragraph 9.1.6, "The contractor shall employ a BCBA or a master's/doctoral level professional in a like-specialty to complete the clinical necessity reviews." This activity may result in the contractor reaching out to the provider.

300. The requirement in 8.6.2.4 states that the contractor has 5 business days to review authorizations. Is that review and approve?

Response: The clock starts when all requirements are met meaning that a compliant treatment plan must be submitted. Should there be issues or concerns that need to be addressed by the provider, or updates required to the treatment plan based on the clinical necessity review, those may fall outside of the 5 day window. Additionally, the 5 business days is the timeframe the contractor has to make a determination, i.e. approval or denial. Please note that clinical necessity reviews were previously conducted after two years of consecutive services (i.e. four six-month authorizations) and will now be completed prior to authorization for all treatment requests at the first and each subsequent six month interval.

301. Will the clinical necessity reviews start with new reauthorizations requests or will they also be auditing current plans?

Response: Clinical necessity reviews occur with each request for authorization of 6 months of services. – Clinical audits and TP reviews are not new processes. TRICARE policy has required services to be clinically necessary prior to these recent updates.

ABA Discharge Summary

302. What CPT code should be used for discharge summaries?

Response: There is no CPT code for writing a discharge summary as this is an indirect service. This activity should be part of best practices when transitioning a beneficiary out of care.

303. To whom do we submit the discharge summaries?

Response: Discharge summaries should be maintained in the beneficiary's medical record and submitted to the contractor.

304. Is there a specific discharge summary form?

Response: DHA has not developed any required forms. Please contact your contractor for additional guidance.