TRICARE ACD Manual Change Webinar

Session 3: ABA Policy (8.0)

April 16, 2021

Agenda

- Welcome and Introductions
- Provider Requirements
- Referrals
- Authorizations
- Outcome Measures
- Documentation
- Discharge Planning
- Quality Monitoring/Oversight
- Exclusions
- CPT Codes
- Concurrent Billing
- Implementation Timeline
- Q&As

Webinar Housekeeping

- Phone lines and Adobe Connect are in listen-only mode
- Questions may be submitted via the ACD email (dha.acd@mail.mil) or via the Q&A box in the Adobe Connect platform
- Please be respectful with your questions/comments
- Webinar is being recorded
- Slides and a PDF of the manual are available for download via Adobe Connect during the presentation in the downloads box
- Slides and recordings will be posted on www.health.mil/autism following this presentation

ACD Manual Changes – Published

- TRICARE Operations Manual Chapter 18, Section 4: "DoD Comprehensive Autism Care Demonstration"
  - Published: March 23, 2021

- https://manuals.health.mil/pages/DisplayManualHtmlFile/2021-03-23/AsOf/TO15/C18S4.html

ABA Provider Requirements (8.2-8.4)

- All providers
  - National Provider Identifier (NPI) – New for BTs
    - New providers as of 7/1/21 require NPI in certification packet
    - Current providers have until 8/1/21 to submit
  - Criminal history check – contractors obtaining copy
- Authorized ABA Supervisor/ACSP
  - Resign participation agreements NLT 8/1/21
  - Attend a provider education training annually to begin NLT 1/1/22
- Behavior Technician
  - Contractor must certify within 10 business days of a complete application effective 7/1/21

ABA Referrals (8.6.1-8.6.3)

- Referrals for ABA services for children over age 8 must come from a specialized ASD diagnosing provider effective 10/1/21
- If diagnosis is made more than 2 years prior to requesting ABA services, then an updated assessment/evaluation is required to determine current need (for new beneficiaries effective 10/1/21)
- Align all beneficiaries to a chronological two-year referral timeline

ABA Authorizations (8.6.1-8.6.3)

- All current authorizations run through their existing authorization period.
  - Authorizations after 8/1/21 will incorporate manual changes (i.e., new CPT codes, units, etc.)
- Authorizations for new beneficiaries
  - 1st authorization = ABA evaluation/assessment; may include units for outcome measures
  - 2nd authorization = ABA treatment services
    - All baseline outcome measures must be complete before issuing the treatment authorization
- Clinical necessity reviews will be completed prior to issuing all ABA treatment authorizations beginning 8/1/21

ABA Authorizations cont. (8.6.1-8.6.3)

- Treatment Plan (TP) updates may be submitted up to 60 days in advance
  - Effective 8/1/21, TP may be submitted incorporating ACD revisions (i.e., additional CPT codes)
  - TPs submitted prior to 8/1/21, even if effective after 8/1/21 will not be eligible for new codes
- For TPs submitted late, authorizations will not be back-dated
- As of 8/1/21, all outcome measures must be submitted prior to issuing subsequent authorizations

Outcome Measures (8.6.4)

- 4 outcome measures
  - Vineland-3 (baseline and every year)
  - SRS-2 (baseline and every year)
  - PDDBI (baseline and every six months)
  - PSI or SIPA (baseline and every six months) *as of 8/1/21
- All outcome measures must be completed prior to issuing treatment authorizations
- All outcome measures require prior authorization
- After 8/1/21, all authorized outcome measures issued to a BCBA will submit CPT code 97151 (T1023 deleted as of 8/1)
  - Continue to use T1023 under your current authorization
  - Requests for outcome measure units must be submitted with treatment plan updates
- Publisher reports must be submitted (no transposing scores into the TP) effective 8/1/21

ABA Documentation (8.7)

- TP development – elements have been reorganized to flow logically
  - DHA will not provide a template, however, you can use 8.7.1 as a guide
  - Comorbid conditions
- Progress Notes
  - Additions include references to how to document group sessions
  - DHA will not provide a template, however, you can use 8.7.2 as a guide

ABA Discharge Planning (8.8)

- Previously titles “Periodic ABA Program Review”
  - More accurately describes activity
  - Transition/termination of services
- Documentation of discharge from services
  - Whenever a beneficiary leaves your services, you must document a summary.

ABA Quality Monitoring and Oversight
(8.9)

- Contractor responsibility
  - ❑ Audit of documentation records
    - Administrative
    - Medical records
    - New providers
  - ❑ Audit of provider certification requirements

Exclusions (8.10)

- Targets addressing non-core symptoms of ASD
- ADLs, i.e., folding laundry, setting the table
- BT services in the school setting (any educational setting)
- Certain community settings, i.e., sporting events, camps
- Non-ABA interventions, i.e., CBT, ACT, PE, VR, etc.
- Aversive techniques/restraints
- BT supervision
- Concurrent billing
- Billing for ABA while at another appointment
- Billing for ABA provided by an agency owned by family

CPT Code Updates and Additions (8.11.6): Effective 8/1/21

- Revisions to CPT Codes
  - 97151
  - 97153
  - 97155
  - 97156
- Additions of CPT Codes
  - 97157
  - 97158
  - 99366/99368
- Deletion of CPT Codes
  - T1023

- Treatment plans submitted after 8/1/21 may include new provisions.
- TP submitted before 8/1/21 are ineligible for new provisions.

CPT Code Updates and Additions: 97151 (8.11.6.2.1) (Effective 8/1/21)

- Initial assessment: up to 32 units (increased from 16 units)
- Subsequent authorizations: up to 24 units (increased from 16 units)
- Must be conducted within a 14-day period
- Outcome measures will be reimbursed from this code (see deletion of T1023)
- Involves both direct and indirect activities
  - Note this is the only code that permits billing for indirect activities
- Not eligible for rendering via TH

CPT Code Updates and Additions: 97153 (8.11.6.2.2) (Effective 8/1/21)

- Authorized for up to 32 units per day; up to 160 units per week
- Not eligible for rendering via TH

CPT Code Updates and Additions: 97155 (8.11.6.2.3) (Effective 8/1/21)

- Authorized for up to 8 units per day
- Must be completed at least once per month
  - If this does not occur, a 10% claims penalty may result
- Team meetings and supervision are not reimbursable services under this code
- Not eligible for rendering via TH

CPT Code Updates and Additions: 97156 (8.11.6.2.4) (Effective 8/1/21)

- Authorized up to 8 units per day
- After the initial six-month authorization, 97156 may be authorized via telehealth
- First session must be within the first 30 days of treatment
- A minimum of 6 parent/caregiver sessions are required every 6 months
  - These 6 sessions can be a combination of 97156 and 97157
  - If not completed for two consecutive authorization periods, ABA services will cease
- Not authorized in school setting
- COVID-19 provision

CPT Code Additions: 97157

(8.11.6.2.5) (Effective 8/1/21)

- New code to the ACD "Multiple-Family Group Adaptive Behavior Treatment Guidance"
- Used by the ABA supervisor or delegated to the assistant behavior analyst
- Groups must not exceed 8 participants
- Beneficiary should not be present
- Authorized for up to 6 units per day
- Reimbursement rate mirrors CPT code 90853 (group psychotherapy) for each participant
- Not to be used for parent psychoeducation or group therapy
- Not eligible for rendering via TH

CPT Code Additions: 97158

(8.11.6.2.6) (Effective 8/1/21)

- New code to the ACD "Group Adaptive Behavior Treatment by Protocol Modification"
- Used by the ABA supervisor or delegated to the assistant behavior analyst
- Groups must not exceed 8 participants
- Authorized for up to 6 units per day
- Reimbursement rate mirrors CPT code 90853 (group psychotherapy) for each participant
- Not to be used for psychoeducation or group therapy
- Not eligible for rendering via TH

CPT Code Additions: 99366/99368

(8.11.6.2.7) (Effective 8/1/21)

- Purpose of code is to provide a mechanism for reimbursement of Medical Team Conferences
- One unit of each (99366 and 99368) will be authorized for every 6-month authorization period
- May be used via telehealth or face-to-face
- 99366:
  - Medical team conference with patient
- 99388:
  - Medical team conference without patient

CPT Code Additions: 99366/99368 cont. (8.11.6.2.7) (Effective 8/1/21)

- Requirements set by AMA (not TRICARE)
- Requirements for reimbursement:
  - A minimum of three qualified health professionals from 3 different specialties or disciplines.
    - Example: ABA provider, PCM, speech therapist
    - No more than one provider from same specialty
  - Reporting participants must be present for the entire medical team conference
  - Reporting participants must have performed an evaluation of treatment of the patient within the previous 60 calendar days
  - When a beneficiary is assigned an ASN, the ASN must be present

CPT Code Deletion: T1023

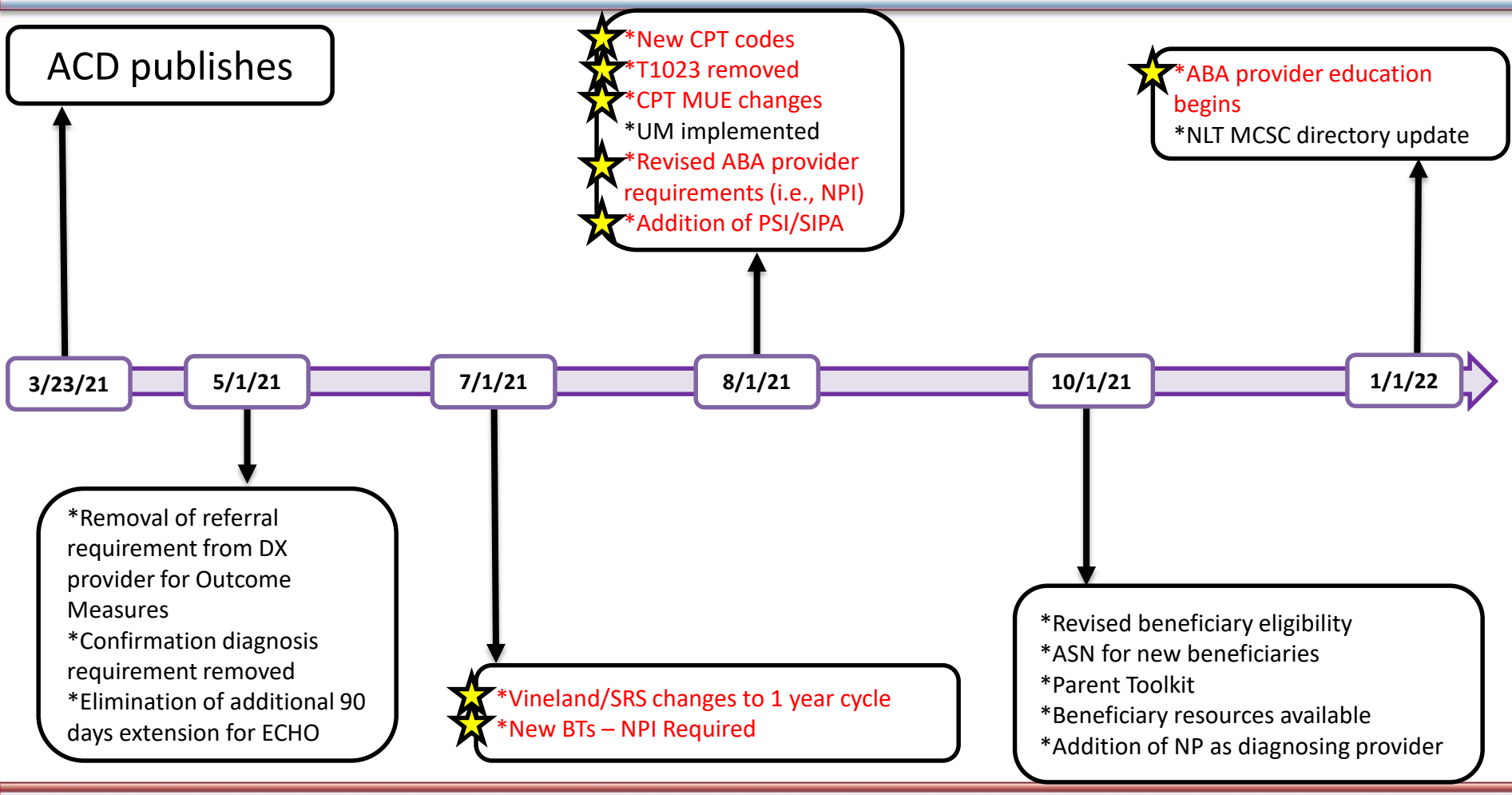
(8.11.6.1) (Deleted 8/1/21)

- Deleted
- Use 97151 for outcomes
- Current authorizations run through their duration; subsequent authorizations after 8/1/21 will no longer issue T1023

Concurrent Billing (8.11.7.3.8)

CPT Code	97151	97153	97155	97156	97157	97158
97151	N/A					
97153	Y	N/A				
97155	N	N	N/A			
97156	Y	Y	Y	N/A		
97157	Y	Y	Y	N	N/A	
97158	Y	N	N	Y	Y	N/A

Phased Implementation Timeline



Please submit policy questions regarding this manual change to the ACD email

dha.acd@mail.mil

Do not send PII/PHI

QUESTIONS

Submitted Questions

- *Does a school employed SLP or OT qualify as QHPs? Would they be required to attend the meeting (I understand from the description that they would not be reimbursed)? If they are considered QHPs, would they be required to complete documentation for Tricare for their participation in the meeting?*
  - *No. The MTC participant must be TRICARE authorized to meet the MTC requirements. Non-TRICARE authorized SLPs/OTs can participate, but they do not count as the one of 3 QHPs. Also, those non-QHPs, would not need to complete any documentation.*

- *Are all Tricare authorized providers aware of this new requirement with ACD to attend the MTC and the requirement for documentation?*
  - *MTC is not a "requirement," but rather a mechanism to encourage all treating providers to communicate. Documentation is required for all billable services. MTC is a code available under the TRICARE benefit.*

Submitted Questions

- *If the child does not have an ASN can CPT code 99366 and 99368 still be billed?*
  - *Yes, pending that all requirements for MTC are met.*

- *When the physician referral for T1023 is no longer required on 05/01/2021, will ABA providers still need to obtain an authorization?*
  - *Yes. All outcome measures require prior authorization. The PDDBI will automatically be added to 97151, but the other outcomes measures will be prior authorized by the contractor.*

- *How will the current authorizations work as the T1023 is removed and the addition of other codes and/or units?*
  - *Current authorizations run through their current authorization period. Once the new codes/revisions take effect, and a new treatment plan is authorized, then T1023 will no longer be authorized for those TPs after 8/1/21.*

Submitted Questions

- *Are sole providers required to complete code 97155 at least one time per month? I am my own supervisor.*
  - *The purpose of 97155 is to assess/modify the TP protocol between 6-month assessments. So yes, all authorized supervisors, regardless of model type (sole vs tier) should be using this code to update targets throughout the authorization period. If you are completing these updates under another CPT Code, please revise your process as that is not the purpose of the other codes. Also, don't forget to document.*
- *The new guidelines state that 97155 must be conducted 1x/month. If a BCBA is providing 100% of all services using a sole provider model, is this code still required monthly or else we risk recoupment and/or denials? We do provide near constant and daily modifications to programming, protocols, techniques, and procedures as those needs arise and document this in our session note for 97153 sessions.*
  - *Protocol modification should be billed as 97155. While activities under 97153 and 97155 may occur seamlessly, these are distinct activities and should be billed separately. All BCBAs regardless of model type, should be billing for 97155.*

Submitted Questions

- *When are the new reimbursement rates available?*
  - *The reimbursement rates update are currently available of www.health.mil/autism.*
- *If we receive a referral but have a waitlist, how does that affect the 28 days?*
  - *You should not be accepting beneficiaries if you have a waitlist that is longer than 28 days. Please notify your contractor if you have a waitlist. Alternatively, if you want to keep the referral, perhaps you could start by providing services to the parents while you hire more staff.*
- *How should ABA practicing providers handle upcoming re-authorizations for continued services for patient's whose expiration dates range from 5/1 through 8/1?*
  - *Continue to submit as you typically would.*

Upcoming Webinars

- Series of Meetings:
  - April 21, 2021 @ 1300 ET – Other Important Changes
- Submit Questions in Advance
  - Please submit all questions and we will address accordingly
  - Questions will be addressed during relevant webinars
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