Questions and Answers
Autism Roundtable
Dec 3, 2015

Behavior Technician Certification Requirement

Q: How do you propose to increase the required education without paying enough for the support team?

A: The certification requirement is an advancement in the applied behavior analysis (ABA) field. It was developed by the Behavior Analysis Certification Board (BACB), the main certification body for the ABA field. We included this certification requirement because the profession is moving toward becoming a medical profession. We don't reimburse for the training of any providers in any medical field.

Q: Just to clarify, will ALL behavior technicians (BTs), even legacy BTs, need to be certified?

A: Yes. All BTs must be certified from one of the three certification bodies: BACB, BICC (Behavioral Intervention Certification Council) or QABA (Qualified Applied Behavior Analysis). BTs TRICARE-authorized before Dec. 31, 2015, must be certified by Dec. 31, 2016. BTs hired on or after Jan 1, 2016 must already be certified before becoming a TRICARE-authorized BT.

Q. If we get non-certified BT applications into TRICARE before Dec 31, 2015, will they be offered the Dec 31, 2016, extension for certification?

A: Yes. All completed applications received before Dec 31, 2015, will qualify for the Dec 31, 2016, BT certification requirement extension deadline.

Q: We request that a grace period of 3-6 months be given to allow time for BTs to obtain the credentials without holding up services after Jan 1, 2016.

A: No grace period is being offered to the new BTs hired on or after Jan. 1, 2016. Again, we don't reimburse for provider training.

Q: Since BTs hired after Jan 1, 2016, are required to be certified before rendering services, how will this additional training of BTs be reimbursed by TRICARE?

A: We don't reimburse for training under any medical benefit. Training of BT employees is a practice expense.

IEP

Q: There currently isn't a code for coordinating with teachers. Would TRICARE consider adding a code for this?

A: Coordination of services with other professionals is already incorporated into each AMA CPT code, as this is considered an administrative task.

Q: If a child has an Individual Education Plan (IEP) or Individualized Family Service Program (IFSP) but their parents won't release it to us and/or TRICARE what do we need to give TRICARE for an authorization to be approved? Is a letter of attestation from the parents saying they will not release it good enough to send in to TRICARE for the authorization to be approved?

A: The IEP, or an attestation that one is not available, is required before ABA services are authorized. The IEP confirms ABA services aren't duplicated and provides clinical information needed to assess the child and development of a treatment plan.

Q: Who is currently responsible for sending in the IEP? And who is responsible for it in the future?

A: The current TRICARE Operations Manual (TOM) language requires the diagnosing/referring provider to submit the IEP. However, as announced at the Autism Roundtable on December 3rd, that responsibility will shift to the Board Certified Behavior Analyst (BCBA) in the next manual revision. The regional contractors are accepting the IEP today and going forward from any reliable source.

Q: IEPs are usually only updated annually. Why is TRICARE requiring us to send them in 2 times per year?

A: The TOM is being updated to require the IEP once annually or whenever changed.

Q: Will TRICARE authorize or pay for BCBAs to attend IEP meetings now that they're requiring ABA goals to be in sync with IEP goals? What code should be billed for this service?

A: Ensuring that the ABA treatment plan goals and the IEP goals don't overlap is good practice. Participation in IEP meetings isn't a medical service, it's an administrative function already included in the covered ABA services. Therefore, there isn't a CPT code that can be reimbursed separately from otherwise covered services.

TOM Programming Questions

Q: Will the Basic Life Support (BLS)/Cardiopulmonary Resuscitation (CPR) equivalent certification still be required by Dec. 31, 2015?

A: Yes. There is no extension for this certification requirement. All providers must be certified by Dec. 31, 2015. This guarantees our beneficiaries can receive timely lifesaving measures from ABA providers in the event of a medical emergency.

Q: Please provide clarity: is the requirement "CPR and BLS" or "CPR or BLS"?

A: The requirement is for one certification. It can be either BLS or CPR equivalent.

Q: Can the 0359T code be billed now at any time within the authorization period?

A: The current TOM says that it can only be billed once per authorization period. It'll be changed to read, "except during the first authorization period, which allows claims for 0359T to be submitted twice." This will ensure ABA providers receive timely reimbursement. The reassessment should coincide with the next authorization request, which can be submitted within 60 days prior to the next authorization.

Q: Can we have goals on our home-based plans that overlap with IEP goals? Can we have goals that may be deemed academic, such as math or reading goals?

A: ABA treatment goals may overlap with the IEP goals. However, intervention methods must be distinguished and can't be opposing or counter-productive. Academic goals are prohibited from the Autism Care Demonstration (ACD), but there may be pre-requisite skills that are acceptable so that the school environment may teach the academic goals.

Q: How will the BT certification requirement change for BTs hired before 2016 impact billing processes since the change can't be implemented until the updated policy manual has been revised and released?

A: The regional contractors have been notified and instructed to implement this change immediately. The BTs currently TRICARE-authorized will be extended to December 2016 to ensure all claims are processed correctly. The manual change is in coordination with a publication date expected in late-February 2016 or early March 2016..

Q: Why don't you allow 0359T to be billed with 0360/0361T on the same date of service? These codes are allowed to be billed together per the CPT guidebook and the definitions match what needs to be done during the initial evaluation. This would allow for additional hours to be billed for that initial evaluation.

A: Under our ACD authority, CPT code 0360T/0361T was modified for the TRICARE ACD to cover supervision, since supervision is not a covered service. We did not use the AMA CPT code description for this code as described; therefore, billing 0360T/0361T as an extension of the 0359T is prohibited. Separately, 0359T and 0360T/0361T can be billed on the same day, but for different purposes (reassessment and supervision, respectively).

Reimbursement Questions

Q: I understand that families are only responsible for copays/cost shares. However, there is still 5% of the billing rate not covered by TRICARE, so wouldn't the family be responsible for that 5% as well?

A: No, the family can't be billed the 5% since that is the discount the provider negotiated with the regional contractor.

Q: Will the in-network reduction of 5% still take place on top of this rate reduction?

A: Yes. The 5% reduction is the rate negotiated between a provider and the regional contractor. The benefit for the provider is they are considered "in-network" and therefore considered first for all referrals.

Q: In light of the new rates, will a code be added to reimburse for material development/research and program modifications done at the office?

A: No. These services are considered part of the practice expense and are already incorporated into the current CPT codes. The ABA field worked hard to get official AMA CPT Category III codes for ABA services, which we have adopted. They are defined as "a temporary set of codes for emerging technologies, services, and procedures." See the AMA website for more information: http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/category-iii-codes.page

ABA professionals continue to work toward the establishment of ABA Category I CPT codes, which are for proven medical care. We fully support this effort and the evolution of ABA from an education service to proven medical care.

Q: When will the final rates be released?

A: Both the "actual" and "capped" 2016 ABA reimbursement rates are available on www.health.mil/abarates. The "capped" rates, which may be adjusted in Jan-Feb 2016 during a second review of the statewide Medicaid rates, will be implemented in March or April 2016 with the annual CHAMPUS Maximum Allowable Charge rate release.

Please note, the "actual" rates are displayed for comparison purposes only. The rate calculation was completed by adjusting the National Rates presented at the ABA Roundtable on December 3rd using the same geographic locality factors used to adjust all TRICARE rates. The rates will be adjusted annually based on the statewide Medicaid rates to ensure no rate is reduced by more than 15% until the calculated rate applies.

This process ensures ABA rates are reviewed and adjusted annually, like all other TRICARE rates, and not left unchanged for another seven year period.

If Medicare establishes rates for the eight CPT codes TRICARE recognizes, those rates will immediately be adopted as required by law.

Q: How did the RAND Corporation study determine the rates?

A: The RAND Corporation report is currently pending final DoD approval for release, which is required for all RAND reports. Once approved to release, the report will be available at www.health.mil/autism. Please refer to their report for the details regarding how they collected and reported information. We expect both the RAND Corporation, and Kennell and Associates reports to be posted the week of Jan 4, 2016.

Q: How does TRICARE feel about no longer having an edge on attracting and keeping providers in light of these rate changes?

A: We strongly believe our rates remain very competitive nationwide based on the two rate studies received by RAND Corporation and Kennell and Associates. Adopting these new rates and the re-calculation process will ensure the reimbursement rates are reviewed annually like all other TRICARE rates and not left unchanged for another seven-year period. We believe TRICARE offers one of the best benefit plans in the country, with no annual visit or dollar caps and minimal collection efforts by providers.

Q: Can the rate change be postponed since organizations are required to completely restructure how they practice and their annual budgets?

A: No, the rate change will be implemented as scheduled. Notification of this rate change was discussed at the past Roundtable conferences and published in the May 29, 2015, Federal Register amendment. While the exact rates were unknown at that time, the publication stated that no region would experience more than a 15% rate cut each year until the actual calculated rate was achieved.

Q: How do we know which reimbursement rates apply to our practice?

A: The reimbursement rate is determined by the zip code for the place of service.

Q: The delayed rate change last year was specific to the BCBA direct service rate. The rates for 2016 resulted in rates for all billing codes in most localities that are 15% lower than current rates. No indication was ever provided to service providers that other rates would be cut/changed.

A: When the proposed rate change was put into abeyance in Oct. 2014, the Under Secretary of Defense for Personnel and Readiness directed the RAND Corporation to review all codes for all provider types. Subsequently, the amended Federal Register May 29, 2015 notice stated that "the Department responded by placing the rate reduction in abeyance pending a complete analysis of the Autism Care Demonstration (ACD) reimbursement rates..." "As a result of this extensive analysis, the Department will adjust ABA reimbursement rates under the ACD to be more consistent with other payers and implement geographic adjustments based on GPCI (Geographic Practice Cost Index)."

Q: What exactly is the process for determining these rates?

A: The DoD examined the rate analysis provided by the RAND Corporation and considered four different calculation formulas developed by Kennell and Associates. The methodology selected is consistent with how all other TRICARE benefit rates are determined when there is no Medicare rate established. It involved examining Medicaid rates in all 50 states and adjusting them to approximate Medicare rates, which are usually higher than Medicaid.

If Medicare establishes rates for the eight CPT codes TRICARE recognizes, those rates will immediately be adopted as required by law.

Q: When calculating the rates, did the Defense Health Agency (DHA) take into account the non-billable costs associated with providing services under the ACD that other commercial insurance companies don't require?

A: No. Non-billable services are excluded from coverage and reimbursement. The AMA Category III CPT codes incorporate the pre/post work, as well as the actual ABA services provided.

Q: Did the DHA take into account that several commercial companies allow for billing of the Board Certified Behavior Analyst (BCBA) and the BT during supervision sessions when looking at the reimbursement rate?

A: No. Under the ACD authority, we modified CPT code 0360T/0361T to incorporate supervision. We have always prohibited double billing for the same service delivered at the same date and time.

Q: How do we transfer our families if we choose to leave TRICARE?

A: Please notify your regional contractor as soon as you make your final decision. Regional contractors will work with families to transition them to other providers. We would appreciate you providing notification and help transferring your beneficiaries as outlined by the BACB.

Q: If TRICARE can't reimburse for both BCBA and BT providers during supervision, then how can it be required? Shouldn't the rate for supervision be higher?

A: Under the ACD authority, we modified CPT code 0360T/0361T to incorporate supervision. The rates for supervision are higher than the one-on-one ABA therapy rates. Our requirement for supervision is in line with BACB's requirement for supervision.

Research

Q: Why is TRICARE asking providers to do research on top of providing ABA services?

A: We aren't asking providers to do research. Our request for outcome measures is two-fold. We are looking to the field for the best measures being used to demonstrate improvement to develop a future research project. The second objective is to meet a primary goal of the ACD – provide Congress a report on the effectiveness of ABA services for beneficiaries with autism spectrum disorder (ASD).

Q: How is it that DHA/TRICARE considers ABA an unproven treatment for ASD?

A: We completed an ABA benefit determination review in 2010, 2013 and continually monitor the status of ongoing ABA research. Although ABA shows promise, it hasn't been shown to meet the TRICARE coverage requirements of 32 C.F.R. § 199.4(g)(15) to be a scientifically proven medical/psychological care for ASD. The legal definition regarding proven medical care that governs what TRICARE may cover is far more restrictive than what may be generally considered "medically necessary" in the larger health care industry, including Medicaid programs and FEHB plans. Under commercial plans in particular, many unproven benefits are covered with premiums adjusted accordingly and without requiring scientific proof of efficacy. TRICARE, in contrast, is not health insurance – it is a statutorily-defined health benefit program enacted by Congress. The longstanding TRICARE coverage standard was clarified nearly two decades ago [Federal Register, Volume 62, Issue 3 (Monday, January 6, 1997), pages 625-631]. In that final rule, TRICARE is referred to by its earlier name of "CHAMPUS". The reasons for imposing a high standard of scientific proof for TRICARE coverage were set forth as follows:

"Under statutes governing CHAMPUS, including 10 U.S.C. 1079, CHAMPUS payments are prohibited for health care services that are "not medically or psychologically necessary." The purpose of this provision, common in health care payment programs, is to prevent

CHAMPUS beneficiaries from being exposed to less than fully developed and tested medical procedures and to avoid the associated risk of unnecessary or unproven treatment. CHAMPUS regulations and program policies restrict benefits to those procedures for which the safety and efficacy have been proven to be comparable or superior to conventional therapies. In general, the CHAMPUS regulations and program policies exclude cost-sharing of procedures which are unproven, including those that remain in a developmental status. The evolution of any medical technology or procedure from unproven status to one of national acceptance is often controversial, with those members of the medical community who are using and promoting the procedure arguing that the procedure has national acceptance."

The 1997 Federal Register publication further explained that "[t]his final rule does not present new agency policy. Rather, it reaffirms and clarifies existing CHAMPUS policy in the body of the CHAMPUS regulation."

Although much has been published asserting that ABA is the most effective treatment for ASD, there are currently no studies that meet the definition of proven medical care that governs the TRICARE program – specifically: "[w]ell controlled studies of clinically meaningful endpoints, published in refereed medical literature". Specifically excluded from consideration under TRICARE coverage requirements are reports, articles, or statements by providers or groups of providers containing only abstracts, anecdotal evidence or personal professional opinions. Also not included in the meaning of reliable evidence set forth at 32 C.F.R. § 199.2(b) is the fact that a provider or a number of providers have elected to adopt a drug, device, or medical treatment or procedure as their personal treatment or procedure of choice or standard of practice.

In order for ABA to be scientifically proven for TRICARE coverage purposes, there must be published findings of randomized clinical trials (RCTs) establishing its efficacy. As discussed at length in the 2013 ABA benefit determination, the few RCTs studying intensive ABA models that have been published had methodological flaws and/or conflicting findings that prevent them from rising to the level of reliable evidence. The reason for most ABA studies not meeting the reliable evidence standard as a "well-controlled study" was the lack of randomization in subject assignment. If ABA is to be authorized as a medical/psychological treatment under TRICARE, there must be published scientific proof that meets the longstanding legal standards governing TRICARE coverage.

Note, the AMA CPT codes implemented are still Category III codes defined as "a temporary set of codes for emerging technologies, services and procedures". (See the AMA website: http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/category-iii-codes.page)

Q: If ABA is not an established treatment for autism, then why was it the only treatment indicated as treatment for ASD and it is still the primary established treatment in the most recent report that was published in 2014? Additionally, why are there 30+ states mandating insurance coverage for ABA as a medically proven effective treatment and Medicaid is now mandated to cover ABA as an evidence-based treatment?

A: Assertions that ABA is the most effective treatment for ASD are not the same as saying that ABA is scientifically proven to effectively treat or cure ASD as documented in well controlled studies of clinically meaningful endpoints, published in refereed medical literature. We agree that ABA shows promise in addressing the effects of ASD, and that currently ABA is the principal therapy offered for ASD, but note that assertions that ABA is the "most effective treatment" for ASD are frankly made in the absence of any published findings of randomized clinical trials (RCTs) establishing its medical efficacy. In other words, ABA is held out as the "most effective treatment" for ASD because it is generally the only "treatment" offered many families (apart from the other proven medical/psychological treatments otherwise covered – to include speech, physical therapy, occupational therapy, etc.).

State mandates are often a result of lawsuits and/or legislative enactments. Coverage of a treatment as a result of a court order or state mandate is not equivalent to the treatment being scientifically proven medical care. As discussed in our response to "How is it that DHA/TRICARE considers ABA an unproven treatment for ASD?" TRICARE coverage requirements were established decades ago and depend on a treatment being scientifically proven based on a hierarchy of reliable evidence that limits what references may be considered. Specifically excluded from consideration under TRICARE coverage requirements are reports, articles, or statements by providers or groups of providers containing only abstracts, anecdotal evidence or personal professional opinions. Also not included in the meaning of reliable evidence set forth at 32 C.F.R. § 199.2(b) is the fact that a provider or a number of providers have elected to adopt a drug, device, or medical treatment or procedure as their personal treatment or procedure of choice or standard of practice.

In addition to meeting the reliable evidence standard, Category I CPT Codes must also exist for TRICARE to process claims under the Basic Program (the medical benefit plan). ABA Category III CPT codes were just created in July 2014. Category III codes are temporary AMA CPT codes for "emerging technologies, services, and procedures" that are not yet considered "proven medical care" by the AMA CPT (see link referenced in the previous question above.). We are prohibited from covering treatments with only Category III CPT codes under the Basic Program; hence, all coverage is currently being provided under the "autism care demonstration". We fully support continued research on ABA that will one day meet our reliable evidence standard as scientifically" proven medical care under the TRICARE standards and also the development of Category I CPT codes for ABA.

Q: There are wait lists for ABA services. How does TRICARE intend to resolve this problem?

A: If a TRICARE beneficiary with ASD is on a wait list to see an authorized ABA provider, or if stakeholders (providers, case managers, etc.) know of someone on a waitlist, the appropriate action is to contact the regional contractor immediately for assistance. Each region maintains a current list of providers for ABA services. Also, each region maintains a list of authorizations and beneficiaries without a provider. Currently, those beneficiaries with an authorization may be on a waitlist for several reasons: (1) by choice, (i.e., waiting for a particular provider or waiting for a particular time slot), (2) the parent/caregiver placed their child on multiple provider waitlists in hopes of optimizing their chances for a new patient appointment, or (3) the regional contractor's list of ABA providers accepting new beneficiaries is not current.

We ask ABA providers to notify their regional contractor when capacity is reached and again when appointments open up. The accuracy of network availability information hinges on frequent, two-way communication between ABA providers and the regional contractor. We have directed the regional contractors to reach out to our ABA providers to verify whether they are currently accepting new TRICARE patients. Also, there is a 28-day access to care standard. If you aren't able to see the beneficiary within that time frame, please notify your regional contractor immediately. Please don't hold onto the authorization as there may be other providers able to see that beneficiary in a timelier manner.