TRICARE ACD: Category I CPT Code Changes

Q&As #2

****TRICARE Operations Manual changes pending****

Q31: If all the new codes will be used on January 1, 2019, do I need to update all the existing authorizations to the new codes? Some of the current authorizations will last until April 2019 with the old codes.

A31: No, you do not need to update all of your current authorizations. MCSC systems will be updated behind the scenes to pay the new codes as cross-walked to the old codes. Please refer to the CPT crosswalk that was sent in the invite.

Q32: With the 2 week limit on the 97151 code, do those 2 weeks begin when the authorization is issued OR 2 weeks from when the code is first utilized?

A32: The 14 day period begins when the code is first utilized.

Q33: How do you expect to ensure the quality of care without supervision?

A34: Supervision is still a requirement of the certification board. DHA is relying on the expertise and knowledge of the board to ensure compliance of supervision in the field. Quality of care should not change because reimbursement of a service has changed. The ethical responsibility to provide quality care remains.

Q34: How would you bill for currently authorized fieldwork supervision starting Jan 1 when those codes are no longer recognized and there is not a crosswalk code for 0360/0361T?

A34: You cannot bill for supervision starting January 1, 2019. This is no longer a reimbursable service.

Q35: I am aware that 97153 and 97155 codes will not be eligible for concurrent billing, however, will 97153/97156 be eligible? For example, if a client was with a BT, and then separately, if a QHP and caregiver were working together.

A35: Yes, 97153 and 97156 could be billed concurrently in this situation. Documentation would need to describe where each service occurred and with who, along with the other requirements of a session note. Additionally, the claims should reflect the rendering provider information.

Q36: All claims submitted for services performed on or after January 1, 2019 shall be cross-walked automatically to the new Category I CPT codes for ABA services under the existing authorization I heard multiple times during the 12/12 presentation that CPT III codes will not be accepted after 1.1.2019. Do we cross walk the codes to Category 1 codes on claims after 1.1.2019? OR to the point above, will this be automatic and providers should use CPT III codes?

A36: You will need to bill using the Category I CPT codes after January 1, 2019. Be mindful of how many units you are billing since the codes are now broken down into 15-minute increments.

Q37: Will there be limits to codes per month? For instance, what would the limit for caregiver training be now that it is timed?

A37: The MUEs are set up per day. TRICARE will provide additional guidance on usage for CPT codes, for example, the 14-day window for 97151. For CPT code 97156, the current MUE is 8 unit or 2 hours per day.

Q38: If we structured our unit requests for our current authorizations around 0360T/0361T, can we transfer those units to 97155 usage?

A38: No, supervision is no longer a reimbursable service.

Q39: How do we bill for BT supervision?

A39: You cannot bill for supervision for dates of service on or after January 1, 2019. Supervision is no longer a reimbursable service.

Q40: For the 97156 Family Training code, how is this unit conversion going to work? Does 1 previously untimed unit now equal 1 hours' worth of work?

A40: One unit of 0370T will be converted to 8 units of 97156 (or 2 hours).

Q41: Does the prior rate for 0368T/0369T translate directly to the 97155 code? (For Nevada- is our rate $140.38 or $125?)

A41: Your rates will still be based on the geographically adjusted rate. The $125 is the floor, in other words, rates will not be less than $125. Each code is adjusted accordingly on the rate sheet that was sent out with the invite. The rates are broken down into 15-minute increments.

Q42: What is the difference between old supervision codes and the 97155 codes? We were already using supervision time to make changes, model skills and probe new skills. My understanding is just we need to make sure we document everything we are doing.

A42: Some examples of when 97155 can be used while the beneficiary is present include, but are not limited to: evaluating process, making program changes which could be adding or deleting new step or targets, probing new skills, and modeling the changes for the BT.

Q43: If you are adhering to the strict definition of the codes then why is DHA not adhering to the definitions that there can be concurrent billing by some of these codes?

A43: Concurrent billing has never been allowed as part of the ACD, and is generally not allowed for any services under TRICARE. As we work to move ABA services closer to the basic TRICARE benefit, reimbursement will need to follow TRICARE basic benefit rules. In addition, there is no AMA language in the new Category I CPT codes that specifically allow concurrent billing.

Q44: Was remote supervision previously allowed? (Currently) Or was it never allowed and providers should stop immediately? I understand as far as Jan 1st it will only allow for PDDBI.

A44: Yes. Some (not all) supervision under 0360/0361T could be provided through telehealth. However with the removal of supervision of a separate reimbursable service under the new Category I CPT codes, it will of course not be allowed as a telehealth service either. The PDDBI will continue to be eligible to be provided as a telehealth service. TRICARE is reviewing other potential uses of telehealth in the ABA, but no other uses are allowed at this time.

Q45: For 97155, will it be permitted for the BCBA to direct the BT to probe new skills or changes in the programs with the BCBA taking data to determine protocol modification?

A45: No. Under 97155 the service must be provided by the QHP.

Q46: Do copays apply to both standard and prime members?

A46: Copays vary depending on plan and sponsor status. Please go to www.tricare.mil/costs to identify specific copays that apply to each situation.

Q47: If we have authorizations that are expiring the last week of December, should we write the authorizations with the new Category 1 codes?

A47: Yes.

Q48: For authorizations that are currently pending to begin in January, 2019, where the provider has already written and submitted the progress report with the previous CPT III codes to the MCSC, will those reports be honored or will the providers have to re-write the reports with the new codes? When will these January authorizations be approved?

A48: You do not need to resubmit the authorization with the new Category I CPT codes. However, you will need to submit claims using the new Category I CPT codes for all ABA services provided on or after January 1, 2019.

Q49: Other insurers are using additional codes, such as 90899, to allow for billing of indirect case management. Will DHA consider a code for indirect case management as well?

A49: Case management services are available to our beneficiaries, either through case managers working at the military treatment facility (if the beneficiary is TRICARE Prime and enrolled to an MTF) or through case managers working for the contractor. Thus there is no need for ABA providers to provide case management services to TRICARE beneficiaries. If you believe a beneficiary you are working with would benefit from case management services, please notify the contractor or MTF.

Q50: The removal of billing mechanisms for supervision, concurrent billing, and indirect case management give the impression that DHA is interpreting the AMA coding rules as clinical guidelines for ABA treatment. The AMA has neither the expertise nor an existing framework for applying the elements of Applied Behavior Analysis, which is unique in its application and structure. Not providing for these essential elements of medically necessary treatment results in a

substantial portion of ABA services left at the expense of the provider and undermines the quality of services.

A50: Concurrent billing and indirect case management has never been a covered service under the ACD. The change for supervision is that Category I CPT codes have less flexibility than the temporary codes under Category III CPT codes. Additionally, every provider under every discipline is ethically responsible to provide the highest quality of care. The only change is that DHA is no longer reimbursing for supervision. Supervision is still required per your certification body. The quality of care should not change because a funding source is no longer choosing to reimburse for supervision. Additionally, no other medical service reimburses for supervision. In aligning the ACD closer to a medical benefit, this change is one of many that must occur to make ABA a basic benefit.

Q51: We are alarmed that TRICARE's policy is taking away all the 0360T/0361T supervision units from each case. Typically we only have 3 hours of Protocol Modification per month per case. Is TRICARE going to supplement these authorizations so that the BCBAs have more or as many hours as they had previously? If not, with the new policy it appears that TRICARE expects the ABA agency to either: A) provide the BCBA hours clinically indicated and cover the costs of these services themselves (not bill TRICARE for 4-16 hours of BCBA service per month, depending on the needs of the case), or B) not provide the BCBA hours clinically indicated and provide unethical and ineffective ABA services.

A51: While we recognize the change to the total income regarding the removal of reimbursement for supervision, we anticipate that the BCBA will be able to make up that revenue in other areas such as taking on more beneficiaries, freeing up time from TRICARE's overly restrictive requirements for supervision (now deferring to the certification body's guidance for permitting supervision via direct/indirect services), providing more parent training hours now that the code has changed from an untimed to a timed unit, etc.

Q52: Will BCaBAs be authorized for 1:1 ABA services with clients under the 97153 code? If so, will there be a limit on the number of hours of 1:1 that a BCaBA can provide? (The crosswalk spreadsheet shows that they are authorized, but the slideshow only lists RBT's as eligible providers for 1:1 ABA therapy.)

A52: Yes, the assistant behavior analyst may render 97153. The number of hours provided by the assistant behavior analyst is based on the recommendations of the treatment plan.

Q53: Will BCBAs be authorized to provide 1:1 ABA services? If so, how many hours of 1:1 will BCBAs be allowed to provide daily?

A53: For 97153, BCBAs may still render these services. Those hours will be approved based on medical necessity as it was previously done under 0364T/0365T.

Q54: Will a standardized form be provided for billing 97155?

A54: No. However, the required elements for all session notes are listed in the TOM.

Q55: It is understood that 97153 and 97155 cannot be billed concurrently. We are interpreting concurrently as a session taking place during the same time of the day. However, can they be conducted on the same day at different times? For example, if a BCBA conducts an Adaptive Behavior Treatment with protocol modification meeting (97155) with the patient from 8 am - 10 am, can the RBT conduct a 1:1 session (97153) 10 am - 12 pm on the same day?

A55: Yes. Multiple sessions can occur on the same as this example demonstrates.

Q56: You have stated that the GT modifier is excluded from codes 97151, 97153, 97155, and 97156. Many providers have created a model that incorporates the use of remote supervision in order to provide services to clients in remote locations where a consultant cannot physically get out in person on a regular basis. We have been working strictly within the guidelines of the last TOM outlining the use of remote services and requirements of the in-person meetings. However, you are now only giving 2 week's notice to make systemic changes to a provider's practice, and that is not enough time to transition clients. Per our code of ethics, section 2.15 (c) states that it is unethical to stop services without a proper transition or discharge as it can result in clients having significant regressions in skills and increases in problem behaviors. Two weeks is not enough time to properly discharge or transition clients if we are not able to continue to provide remote services. Providing remote services allows for more consistent and higher quality of service as well as provide services to clients who would not have access otherwise. Current research supports the use of remote consultation and states the effectiveness of this type of service.

A56: The only change to the covered codes is the deletion of reimbursement for supervision. Supervision is still required per your certification. You now have more flexibility in how you conduct supervision than what TRICARE previously required. There should be no other change to any of the other services rendered. Remote services were only applicable to supervision. You certainly can continued to provide supervision remotely. However, the TRICARE change is that supervision is not reimbursed.

Q57: As your motto is a "Medically Ready Force and Ready Medical Force" and your focus is supporting active duty military and their families, it is surprising that you do not allow for remote parent trainings. When an active duty service member is on a deployment workup, he or she may not be physically home for 12 months at a time and unavailable for in-person parent trainings. This results in the active duty member not receiving parent trainings during this time due to the GT modifier being excluded for the 97156 parent training code. Many service members have access to computers or personal devices and internet when training or deployed, making remote parent trainings an option. When the active duty member returns from a deployment or training, he or she is then behind on the parent trainings and the child's progress, resulting in not being medically ready to return home to their families. Additionally, this puts the primary responsibility on the parent who remains at home, and does not foster a collaborative service model. It is essential that due to the nature of the active duty member's responsibilities of being away from home to serve his or her country, that remote parent trainings be available.

A57: Thank you for the suggestion. In efforts to crosswalk the Category III CPT codes to Category I CPT codes for approval, we needed to retain the current benefit as much as possible. Having said that, we are already considering the use of the GT modifier for other codes. We will be able to share any approved changes in the next manual revision.

Q58: Can TRICARE reconsider the time constraint it has placed on 97151, given that the activities in the code descriptor often occur throughout the treatment authorization?

A58: This code (97151) is intended for use in a confined time frame, not to be used throughout the authorization period. The activities conducted throughout the authorization period outside of the assessment should be completed using 97155. Those activities are distinctly different activities than 97151; i.e., a comprehensive assessment vs the day to day review and program update.

Q59: Slide 15 of the slide deck says: "New authorizations will not be required as a result of the transition from Category III to Category I CPT codes, meaning that the current authorization will run its full period and when the next 6th month authorization arrives, a new authorization with the Category I CPT codes will be issued." I take this to mean that existing authorizations with old codes that overlap into 2019 can still be used until they expire. Is that correct? But, slide 16 says: "Do not submit claims for services rendered on or after January 1, 2019 using the old Category III CPT codes " That seems contradictory to what slide 15 is saying. If the existing authorization containing the old codes can be used into 2019 until it expires, how do we submit claims for those dates if we can't use the old codes?

A59: No. The Category III CPT codes will no longer be valid, and everyone must use the new Category I CPT codes. The goal of this statement is that there is no additional work to the provider for each authorization meaning that the current authorization will retain the recommendation, but the codes will be converted to the Category I CPT codes behind the scenes as to not disrupt any services. So you will be submitted 97153 instead of 0364T/0365T, 97155 instead of 0368T/0369T, 97156 instead of 0370T, and 97151 instead of 0359T.

Q60: In the CPT crosswalk 0368/0369T --> 97155 is described as: Adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes (client, QHP; may include technician and/or caregiver). Does this mean that the QHP can work with the client without the technician or caregiver present?

A60: That is correct. 97155 must include the QHP and the client. Any other participants are optional.