TRICARE ACD: Category I CPT Code Changes

Q&As #4

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

Q91: Because TRICARE is no longer reimbursing us for supervision, would we be allowed to bill the client's secondary insurance for supervision? If so, would we still bill TRICARE for the behavior technician's (BT) time? Or would we have to bill the secondary insurance for both the BT and board certified behavior analyst's (BCBA) time?

A91: Per TRICARE Reimbursement Manual Chapter 4, Section 1: "If other coverage exists, TRICARE coverage is available only as secondary payer, and only after a claim has been filed with the other plan and a payment determination issued." You'll have to check with the other insurance policy for rules on payment of other services.

Q92: Regarding session notes, what specific information is being requested when asked "client's response to significant others?" Who are considered "significant others" (parents, caregivers, BTs, familiar adults/peers they are around during treatment in general)? When you ask "response to," are you asking about rapport between the client and others, or generalization of skills to others? Or something else?

A92: In this context, "significant others" refers to anyone with whom the child might interact specifically related to the treatment plan goals. An example might be, "mother is having difficulty obtaining the same response to the goal of eye contact as the BT or father."

Q93: The daily session note guide/template also requests for "degree of progress towards the treatment goals". Is it an expectation for this information to be filled out daily by the BT? The BT can report on how the client performed during the session (outcome of treatment), however, it is the role of the BCBA to review and analyze the data to determine if progress is being demonstrated and/or mastery of goal. That is not the role of the BT.

A93: We agree with this statement. According to the Registered BT task list, it is within the scope of the BT to comment on the progress towards treatment goals such as daily performance observations of the data. This BT skill is contrasted with the BCBA's role of reviewing and analyzing the overall data in the composite picture of progress.

Q94: What specific information are you requesting when asked "include reference to progress regarding the periodic ABA program review"?

A94: The BCBA should document data and progress over the course of time (2 year period) including but not limited to, outcome measures, skill acquisition, and developmental progress, etc. with regards to the treatment goals identified in the treatment plans. This documentation should be completed using objective (standardized) measures to the greatest extent possible.

Q95: If we have a current authorization with 2 units of 0370T per month and we need to crosswalk it over to 97156, does that mean based on the Q40 and Q73 we have 16 units per month of 97156? Or is this in regards to medically unlikely edits (MUEs) for future authorizations?

A95: If you had 2 units of 0370T under an authorization that was issued prior to 1/1/19, those units would crosswalk to 16 units of 97156. However, for future authorizations, the ABA provider should assess the use of this code and include more or less units as medically appropriate for the patient.

Q96: How do you want the codes written in plans that are coming due for reauthorization and also plans that will be for new clients? Have the links to plan requirements been changed to show how to represent the Current Procedural Terminology (CPT) codes?

A96: Please contact your regional contractor for information regarding how to submit unit requests for authorization. In the upcoming manual change, we are attempting to standardize that request. More to follow.

Q97: What will be the new medically unlikely edits for the codes and what are the limits that can be billed on a daily basis for each code?

A97: No changes are being made to any MUE at the present time. However, a review of MUEs is underway.

Q98: Will there still be the restriction of not being able to bill a BT's time when the BCBA is supervising the BT? All other insurance companies allow the BT and the BCBA to bill at the same time being that both providers are rendering a service?

A99: Concurrent billing of 97153 and 97155 continues to be prohibited. Additionally, BT supervision is no longer reimbursed, therefore, there would be no reason to concurrently bill for these activities at the same time.

Q100: Can 97151, 97153, or 97155 be billed concurrently if the provider billing 97151 (BCBA or assistant) is completing non face to face services while a provider (Other BCBA, assistant, or BT) are completing services that fall under 97153 or 97155?

A100: Please see the table below for situations where concurrent billing would be permitted.

	97151	97153	97155	97156
97151	N/A	--	--	--
97153	Y	N/A	--	--
97155	N	N	N/A	--
97156	Y	Y	Y	N/A

Q101: If multiple people (the BCBA and the delegated assistant) are billing units for 97151 within the 2 week period, do you require all of the provider's signatures on the treatment plan? Or is only the ABA supervisor (BCBA) listed on the beneficiary's authorization signature sufficient?

A101: The supervising BCBA's signature is required on the treatment plan. However, each session note should include the rendering provider's signature.

Q102: Will there be copays for clients for billing of 97151 if no other codes are billed on the same day?

A102: Yes. The client would be subject to a copay if no other services are rendered that day. However, only one copay is required for the entire 14 day window.

Q103: For 97155, were 4 hours added to the hours that were cross-walked over from 0368/69 or will beneficiary's authorizations be increased to 4 hours total if they did not have 4 hours a month for 97155 after the change? If a beneficiary had 3 hours of 97155 after the change, would they have 7 hours now or 4 hours?

A103: For authorizations that were issued before 1/1/19, 4 hours were added to all treatment plans. For this example, if you had 3 hours of 0368T/0369T per month, then an addition 4 hours were added for a total of 7 hours per month.

Q104: Are assistants allowed to bill for 97155 directly or does the BCBA need to bill for this service? If the BCBA were to delegate to an assistant, would this be billable under the BCBA or can the other providers bill for services?

A104: Only the BCBA can bill for any ABA service, regardless of the rendering provider. An assistant or a BT would not be eligible to submit claims independently. Those claims would be denied.

Q105: It was highlighted that 97156 and 97153 it must be done in different locations. What if the beneficiary is receiving services with a BT at home (97153) and a BCBA is providing parent training to the parents at home (97516)? Then this would be the same location.

A105: The intention for separate locations in that the two pairs are not working in the same room. Therefore, the note should indicate the BT and beneficiaries are in one room, perhaps the "treatment room," and the parents are in another room, the kitchen for example.

Q106: What is the additional monthly 4 hours of 97155 for?

A106: Over the course of the CPT code change, it became clear the providers were not using 0368T/0369T as intended per the definition in the TRICARE Operations Manual (TOM). Some providers were using 0360T/0361T to bill for protocol modification. In an effort to relieve this problem for current authorizations, an additional 4 hours per month or 16 units of 97155 was authorized.

Q107: You mentioned T1023 is the only code that allows for telehealth. We had a provider using Telehealth for 0368T/0369T before the change in codes. Can you verify this is no longer acceptable?

A107: No one should have been rendering 0368T/0369T via telehealth. That was never an approved service. Additionally, 97155 is not permitted via telehealth. Providers must stop this practice immediately.

Q108: Centers for Medicare and Medicaid Services (CMS) has said that, effective January 1, 2019, the MUE for 97151 is 32 units. While the change is retroactive, the publication of the change will not occur until April. Will you update your Q&A to reflect the new MUE?

A108: No changes are being made at the present time. However, a review of MUEs is underway.

Q109: In one of the slides it states "one cost-share/copayment" Will ABA start having a co pay?

A109: Not all beneficiaries have a copay/cost-share. Please check the beneficiary plan for information regarding copays at https://www.tricare.mil/Costs/HealthPlanCosts/TS.

Q110: If our BCBA is doing protocol modification while our tech is providing treatment, can 97153 and 97155 be billed for that same date?

A110: No. The BCBA rendering 97155 and the BT rendering 97153 is considered concurrent billing and is not permitted.

Q111: If the BCBA and BT provide treatment to the same child on the same date (not overlapping time), can that happen?

A11: Yes. So long as these two service do not overlap, they can be billed on the same day. Session notes should reflect the session times and rendering provider.

Q112: Can you please explain the modifier usage/rendering provider information provided on the claim?

A112: There are no modifiers used for rendering provider types. The only modifier currently permitted is the “GT” modifier for the use of T1023 for outcome measures completed remotely.

Q113: Please provide clarification on what can be done during 97155.

A113: Examples of rendering the direct service of 97155 code usage include:

- Authorized ABA supervisor works directly with the client conducting probes to try out new or revised protocols with or without the BT present.
- Modifying the treatment plan in the context of direct service assessment and probing
- The authorized ABA supervisor works directly with the client to model implementation of new or revised protocols for the BT or parent.

Q114: Can you provide an example of what a progress note would look like for 97151 where the services were development of the treatment plan, in the office, non-face-to-face? Are there sections of the progress note that it’s acceptable to not answer and what would be appropriate to fill in those sections?

A114: A session note for 97151 should include information regarding what actions took place during that time. For example, if report writing occurred, the note would document sometime such as: No direct assessment occurred during this session. Rendering provider

reviewed medical records, assessment measures, data collected, and completed the first draft of the treatment plan.

Q115: Is it true that you will no longer require at least 5% supervision of direct care hours provided by a BT?

A115: Correct, the requirements for supervision will be removed from the TRICARE Operations Manual.

Q116: What about the requirements for BT for maintaining their credential?

A116: No changes have been made to the BT certification requirements. All BTs must possess a certification from a recognized certification body, as well as possess the Basic Life Support/Cardiopulmonary resuscitation certification. Please review TOM Chapter 18, Section 4, Paragraph 6.3 for all BT requirements.

Q117: CPT code 97155 cannot be billed concurrently with 97153 correct? What about when you are supervising and seeing if the BT is maintaining the integrity of the programs?

A117: Correct. Supervision of the BT is no longer a billable service. Only services related to protocol modification are covered. Maintaining treatment integrity is a supervisory activity and therefore not covered.

Q118: If they are looking to change ABA to be a medically aligned service, will the requirements of documentation reduce to align with that of other providers? Overall, ABA is required, through TRICARE, to provide far more documentation than any other profession.

A118: All medical providers are required to produce medical documentation to the same standards as defined in TPM Chapter 5 Section 1, Medical Records Documentation.

Q119: Do BCBAs get reimbursed for the Vineland-3 and/or Social Responsiveness Scale-2? If so, how do you bill that?

A119: Yes, BCBAs can be reimbursed for performing these outcomes measures, but only if the BCBA has obtained an authorization to complete these measures. The authorized units would be T1023 (one unit for each measure).

Q120: When does the 2 week time limitation begin? Does it begin from the date of the assessment or the date from when we receive the authorization?

A120: The 14-day window begins when the first date of rendered 97151 occurs. The authorization date does not determine the beginning of the 14-day window.

Q121: Is watching the BT implement the protocol to determine what is wrong with the procedure covered or if it needs updating covered? If the BCBA is rarely in with the child then the learner will not respond to the BCBA in the same way as someone they are familiar with. We would not usually jump in to try out a procedure without watching what the tech is doing to see what is going wrong for it.

A121: It is expected that the authorized BCBA has regular contact with the beneficiary and the family. The authorized BCBA has clinical oversight and is ultimately responsible for the treatment plan and beneficiary progress. Once the protocol has been modified, directing the BT how to perform the new/modified protocol is covered, however observation to determine if the BT is performing the original protocol appropriate is supervision and is not covered.

Q122: For ABA, is the specialist rate or primary rate used for the cost share? Last year, it was the specialist rate. Has this changed?

A122: ABA services fall under the specialist rate. This has not changed.

Q123: If I have less than 15 minutes of service, would 8 minutes or more but less than 15 minutes, be considered one unit. Example: CPT: 97153 reported 24 minutes. Would I bill it as 2 units?

A123: Per CMS rules, in order to bill one unit of a timed CPT code (in this case a 15 minute unit), you must perform the associated modality for at least 8 minutes. In other words, CMS adds up the total minutes of skilled, one-on-one direct time and divides the resulting sum by 15. If eight or more minutes are left over, you can bill for an additional unit. But if seven or fewer minutes remain, CMS will not reimburse you for another full unit, and you must essentially drop the remainder. To give a simple example, if you performed ABA for 23 minutes (15+8), you could bill two direct time units.

8 - 22 minutes = 1 unit
23 - 37 minutes = 2 units
Etc.

Q124: Can 97155 be done as direct service to client on a regular basis. If so what is the max per day.

A124: CPT code 97155 is not to be used as the direct 1:1 service code for the BCBA. The BCBA should render direct services using 97153.

Q125: The wording for 97155 specifically states: "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." It says "which may include simultaneous direction of technician, face to face with one patient." But this directly contradicts the concurrent billing not being allowed. According to how it reads, I could be at the home, conducting 97155 while the BT is with the patient billing 97153 right?

A125: No. It is TRICARE's policy to not permit concurrent billing of 97155 and 97153.

Q126: I wanted to suggest that 97155 include Team Meetings. In the teleconference, the importance of a multi-disciplinary approach was stressed. We allow outside therapists into our clinic to work with our clients, but we do not have any billing codes that allow us time to collaborate with them. These providers often have codes for team meetings, however, we don't currently have any codes we can use for collaboration.

A126: Team meetings are not a defined service in the American Medical Association Category I CPT code for Adaptive Behavior Services. Therefore, team meetings are not reimbursable under 97155. DHA is reviewing possible options for including medical consultation.

Q127: To clarify, Vineland-3 is required at baseline and every two years, correct? Also, is there a code we can use to bill for this?

A127: Yes, T1023 is the code used to submit for reimbursement when prior authorized.

Q128: Do copays apply to days of service when there is only an assessment billed? Example, we conducted assessment in client home one day and completed treatment plan another day. Is this 2 copays for the family? One for each day of service?

A128: Only one copay will be collected for the entire 14 day window for 97151 regardless of how many assessment sessions or treatment plan writing claims occur.

Q129: Can speech and ABA services be billed at the same time?

A129: No. Two direct delivery services to the same beneficiary cannot be billed at the same time.

Q130: What do I do if I can't answer some of the questions on the PDDBI?

A130: Directions on the PDDBI provide guidance as to how to answer questions based on the beneficiary's symptom presentation. For example, if a beneficiary is non-verbal, then certain questions should not be answered.

Q131: In A72, it says that "Modeling skills/targets specific to the beneficiary's treatment plan" is allowed under 97155. My questions is can the modeling be of current (i.e., unchanged) skills/targets protocols or for this code or must the modeling be for new or modified skills/targets?

A131: No. Direction of the BT under 97155 is limited to new/modified treatment plan goals. Thus, modeling skills/targets that are unchanged would not be covered.