

Autism Care Demonstration – Policy Changes

Questions & Answers – Set 3 (published 7/14/2021)

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.

Referrals/Authorizations

86. For a family who is currently participating in the Autism Care Demonstration (ACD) and who is coming up on their 2-year referral, can the Primary Care Manager (PCM) continue writing the two year referral as long as the child's initial diagnosis was before age 8?

Response: Current beneficiaries are exempt from this requirement. This new requirements begins on 10/1/21 and is applicable to beneficiaries entering the program on or after that date. For clarification, the referring provider is not impacted by this change.

87. Paragraph 8.6.1.3 seems to indicate that the beneficiary still needs to receive a referral every 2 years. Is this correct?

Response: Yes. A referral every 2 years is still required.

88. For beneficiaries moving or changing regions, will their applied behavior analysis (ABA) referral still be valid from the previous managed care support contractor (MCSC) or will they need a new referral?

Response: Active referrals will still be valid when moving until the two-year referral expires. Check with your contractor regarding the remaining duration of the referral.

89. If an authorization request was submitted prior to 5/1, will school/camp services still be allowed?

Response: If an authorization request was approved prior to 5/1/21, then services may have been authorized.

90. For treatment plans that are due before 8/1/21, do the current requirements apply (i.e., only the 4 approved CPT codes)?

Response: Yes. None of the Current Procedural Terminology (CPT) code changes will be effective/eligible for approval prior to 8/1/21.

91. For authorizations that are due after 8/1/21, how should those requests be handled?

Response: Please check your contractors' website or contact your contractor for guidance on specific authorization process questions.

92. Are revisions to existing authorizations permitted?

Response: No. Current authorizations run their course. No modifications are permitted.

93. What is the approval date of an authorization, i.e., if the request was submitted on 8/16/21 and approval was given on 8/20/21, is the authorization date 8/16 or 8/20?

Response: The date of authorization is dependent on a variety of factors. If a complete authorization request is submitted timely and no additional information is required, then the authorization date is the date after the existing authorization expires. However, if the next authorization request is submitted incomplete and additional information is required, then the authorization date is the date all information is received and approved. Please contact your contractor for additional information.

94. Do authorizations have to be in and approved by the expiration of the existing authorization or just submitted by the expiring date? What if something is missing?

Response: To ensure there is no gap in authorized services, it is recommended that completed treatment plan (TP) packets are submitted timely to allow for the clinical necessity review and a determination. The TRICARE Operations Manual (TOM) recommends that providers submit their TP updates as early as 60 days and no later than 30 days before the expiration date of the existing authorization. See your contractor for specific timelines and requirements.

95. If an authorization lapses because the contractor was the source of the delay (not because the authorization was submitted later than the 30-60 day window), is the provider expected to keep services in place and not be reimbursed?

Response: If a complete TP is submitted timely, there should be no delay on the contractor's part for review and determination.

96. Paragraph 8.7.1.6.1 states that the TP should include a request for the number of monthly hours (submitted as units) while paragraph 8.7.1.6.4 states that recommended hours should be submitted weekly hours (submitted as units). Which is it?

Response: Both are correct. Paragraph 8.7.1.6.1 is specific to CPT code 97156 (monthly) and paragraph 8.7.1.6.4 is specific to CPT code 97153 (weekly).

97. If a current authorization has approved goals to perform academic skills, are we able to finish this authorization or must we stop by May 1?

Response: Academic goals have been excluded since the beginning of the ACD.

98. TRICARE has 5 business days to review authorizations. Is that review and approve?

Response: The contractors have 5 business days to complete a clinical necessity review once a complete packet is submitted for ongoing ABA services that is in compliance with the ACD policy. The clock does not begin until a complete packet is submitted.

Parent Stress measures

99. Who is allowed to perform the parent stress measures?

Response: Per the publisher, the PSI requires (Qualification level - S) "A degree, certificate, or license to practice in a health care profession or occupation, including (but not limited to) the following: medicine, neurology, nursing, occupational therapy and other allied health care professions, physician's assistants, psychiatry, social work; plus appropriate training and experience in the ethical administration, scoring, and interpretation of clinical behavioral assessment instruments." For the SIPA (Qualification level – B) "A degree from an accredited 4-year college or university in psychology, counseling, speech-language pathology, or a closely related field plus satisfactory completion of coursework in test interpretation, psychometrics and measurement theory, educational statistics, or a closely related area; or license or certification from an agency that requires appropriate training and experience in the ethical and competent use of psychological tests."

100. For a beneficiary who is 11 years old, which parent stress form should be used (the PSI or SIPA)?

Response: For beneficiaries between the ages of 11-12 years, either measure can be completed as they are within the age band.

101. Does the parent stress measure take the place of the PDDBI?

Response: No. Both measures are required.

102. Can the Short Form of the PSI be used?

Response: Only the Short Form is required. Do not submit the full-length form.

103. Is the parent stress measure due once a year like the Vineland/SRS or every six months?

Response: The parent stress measures are required to be submitted every six months.

104. Is the parent stress measure mandatory that the BCBA has to do?

Response: The requirement is that the parent stress measures must be completed, but the contractor will identify which providers in their network are eligible to complete these measures. A BCBA is one of many provider types who may be able to complete the requirement, but the BCBA is not required to complete the parent stress measures.

105. Can the administration of the parent stress measure be conducted without the BCBA present?

Response: As with all outcome measures, completion of the parent form does not require direct physical oversight. However, the provider authorized to administer the measure, should be available to answer questions (per the guidance in the manuals) to ensure accurate completion.

106. If diagnosing providers are expected to continue to place referrals for outcome measures until 5/1/21, are we [the diagnosing provider] supposed to add the parent stress measure to the referral request?

Response: No. The parent stress measures are not required until 8/1/21, at which time, no referrals for outcome measures are required.

107. Who will be receiving the results of the parent stress measures?

Response: The rendering provider and the contractor will receive the submission of the outcome measures. DHA will receive only aggregate data of these scores.

108. What will be done with the information from the parent stress measures?

Response: For providers, findings from all outcomes measure administered should be incorporated into respective treatment plans. For DHA, aggregate data from all the parent stress measures will be used, in addition to other collected data, to analyze findings to help in the understanding of the impact of the ACD on beneficiaries and their families.

Sharing of outcome measures reports

109. The publisher of the outcome measures do not allow us to share the entire report because the report includes the specific test items and sharing it violates copyright. Please clarify how we should proceed and what specifically you would like for us to provide this information?

Response: We are unaware why submitting the score report to TRICARE would violate a copyright. Note that if the provider fails to submit appropriate documentation necessary to validate the claims to TRICARE, claims will be denied (see paragraph 8.6.4 and 8.9.6). Please note that DHA is requesting the summary score report, not the protocols, nor the protocols populated by the specific questions themselves. As with any third party payer, the medical record is part of the patient's record which is used as part of the validation of the rendered services. Sharing the report, or the entire record, with the TRICARE contractor is not a violation. Each TRICARE contractor possesses the qualified professionals who have sufficient knowledge to receive and review the reports; therefore, release to TRICARE contractors complies with the stated limitation on the cover page of most psychological testing reports: "This report is confidential and is intended for use by qualified professionals who have sufficient knowledge of psychometric testing. This report should not be released to the respondent or to any individuals who are not qualified to interpret the results."

Access to Care

110. When does the access to care requirement (28 days) begin?

Response: This is a current contractor requirement. All specialty care for the first appointment has a 28-day access to care (ATC) standard throughout the TRICARE benefit.

111. If we have a waitlist and cannot see the client within 28 days, should we refer them out? How do we tell TRICARE that we referred them out?

Response: ABA providers are not authorized to "refer" under the ACD. ABA providers should communicate with their contractor if they are unable to accept a referral within the ATC standards for both initial assessment and treatment. While families can choose to remain on a waitlist, TRICARE ACD Providers should not retain TRICARE beneficiaries on any waitlist.

112. Are families no longer able to select their ABA provider?
Response: Families always have a choice in who they select as their treating provider. However, family preference does not ensure access to care (see Note under paragraph 9.3.11.6.4).
113. What does the “Active provider placement” mean?
Response: The contractors are required to identify a provider who can meet the access to care standards. Military medical treatment facility (MTF) directed referrals and family choice do not ensure access to care standards will be met.
114. When you say 28 day access to care, and the 28 days assessment, and 28 days treatment, is that a total of 28 days to complete both, or is that 28 days each?
Response: The access to care standard identified in the ACD means 28 days to obtain an assessment and then an additional 28 days to begin ABA services as approved in the treatment plan.

Outcome measures – referrals/authorizations

115. How do BCBA's get authorized for outcome measures?
Response: Effective August 1, 2021, the reimbursement for the PDDBI will align with the authorized CPT code 97151. Should prior authorization be issued for the remaining outcome measures, additional units on 97151 will be authorized, but this is a contractor decision on who will be authorized for the additional outcome measures.
116. What outcome measures require a referral from a doctor to complete?
Response: No outcome measures under the ACD require a referral from a physician, after 5/1/21. However, the Vineland, SRS, and the parent stress measures require prior authorization from the contactor.
117. If we are able to complete a Vineland (if the doctor is not available), how will we be reimbursed for it?
Response: You must receive prior authorization to be reimbursed for the Vineland, SRS, and/or parent stress measures. If authorized, one unit of CPT code 97151 will be issued for each measure.
118. If a referral for outcome measures is not required, how will the BCBA's be aware if they should complete the outcome measures or diagnosing provider plans?
Response: Please contact your contractor for information about how to obtain an authorization for any outcome measures other than the PDDBI.
119. When the outcome measures are due, will the ASN get a referral for the BCBA to perform them?
Response: Outcome measures do not require a referral. The contractor will determine who is approved to complete the Vineland, SRS, PSI/SIPA. Please contact your contractor for

information about how to obtain an authorization for any outcome measures other than the PDDBI.

120. What code should be requested for outcome measures in TPs due to start July 1, 2021?

Response: For authorizations approved on or after 8/1/21, T1023 will no longer be issued. Instead, the PDDBI (one unit) shall be included in the 32 or 24 units of CPT code 97151. Additional outcome measures that are prior authorized shall be issued one unit each of 97151 when approved by the contractor.