Autism Care Demonstration – Policy Changes

Questions & Answers – Set 4 (published 7/26/2021)

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.

Provider education

121. Who will be required to attend the "provider education"?

Response: *According to the TRICARE Operations Manual (TOM), all Autism Corporate Services Providers (ACSPs) and Sole Provider practices will be required to take the training. This means that whoever is responsible for the practice, must take the training. However, according to paragraph 8.3.9, all authorized providers agree to abide by the rules/regulations, therefore, the responsible provider should be sharing this training information.*

122. Will there be CEUs for the provider education training?

Response: *There are no continuing education units (CEUs) available for this training. The provider education is geared towards educating providers on the TRICARE benefit, ACD requirements, correct billing practices, etc.*

123. What is the Current Procedural Terminology (CPT) code to bill for the time spent in the provider education?

Response: *There are no billable units for attending the provider training.*

124. What will the [provider education] training include?

Response: *Per paragraph 9.3.4, "the contractor shall develop a provider education training,…,that includes at a minimum: ACD requirements (to include ABA provider requirements, correct billing practices/claims filing, authorizations, exclusions, medical records documentation, provider responsibilities, program requirements), Basic TRICARE rules, and 32 CFR 199."*

125. How often will the [provider education] training be offered?

Response: *This is a contractor process question. Please check your contractor's website or contact your contractor for additional details.*

126. Where can I sign up for the provider education?

Response: *This is a contractor process question. Please check your contractor's website or contact your contractor for additional details.*

127. Will the [provider education] training be live or pre-recorded?

Response: *This is a contractor process question. Please check your contractor's website or contact your contractor for additional details.*

128. How long will the [provider education] training take?

Response: *This is a contractor process question. Please check your contractor's website or contact your contractor for additional details.*

129. Will providers have a grace period to complete the provider education?

Response: *The provider education training will begin 1/1/22. No grace period is required. Please check your contractor's website or contact your contractor for additional details.*

130. Please help resolve the following inconsistency: Paragraph 8.3.10 states that the "provider education" training will begin no later than 10/1/21, and paragraph 9.3.4 states that the contractor shall develop a provider education training to be implemented no later than 1/1/22. Please clarify the date

Response: *The provider education training will be implemented no later than 1/1/22. DHA will make this correction in a future administrative edit change.*

Audits

131. Are the annual audit requirements (conducted by the contractor to include a minimum of 30 records for each provider) a new requirement as of this manual change?

Response: *Contractor audit requirements are not new to the ACD. However, this revision improves the contractor audit responsibility.*

132. How will the annual reviews be conducted?

Response: *This is a contractor process question. Please check your contractor's website or contact your contractor for additional details.*

133. Will there be 2 audits conducted annually for every provider (one by the contractor and one by the [TRICARE Overseas Program] TOP and [US Family Health Plans] USFHP contractor?

Response: *Audits will be completed by each contractor with whom you have signed a participation agreement.*

Autism Services Navigator (ASN)

134. Who gets an ASN? If only new beneficiaries after 10/1, what kind of support do the existing beneficiaries receive?

Response: New beneficiaries entering the ACD on or after 10/1/21 will receive an assigned Autism Services Navigator (ASN). Existing beneficiaries have access to case management services through a variety of resources, i.e., the contractors, the military medical treatment facilities (MTFs), and Exceptional Family Member Program (EFMP). Additionally, many of the ASD resources will be available on the contactors' websites accessible for all beneficiaries.

135. Does a referral for ABA trigger a referral to an ASN?
Response: Yes. After 10/1, these referrals for new beneficiaries are synonymous.

136. How soon after the referral to the ACD would the ASN make contact with the family?
Response: Pending all enrollment and eligibility requirements are met, the ASN contact will occur after enrollment has been completed and an ASN has been assigned. There is no expectation that services will be delayed based on the contractor's role. However, if the family does not return the phone call or contact, a delay may be because of that.

137. Will you let the family know who their ASN will be before their first contact so that they are on the lookout for it?
Response: This is a contractor process question. Please check your contractor's website or contact your contractor for additional details.

138. How and when will providers know who is the assigned ASN?
Response: The ASN is assigned to the beneficiary/family, not to a provider. This is a contractor process question. Please check your contractor's website or contact your contractor for additional details.

139. Is the ASN going to be in active communication with the beneficiary's treating providers?
Response: The ASN is assigned to the beneficiary/family. There may be opportunities for the ASN to engage the treating providers, but that is dependent on the case.

140. How often will the ASN be in contact with the beneficiary/family?
Response: The ASN's level of engagement is dependent on the beneficiary/family need, therefore, the number of engagements will be tailored to the individual beneficiary but must occur a minimum of once per six months to update the comprehensive care plan (CCP).

141. What will be the ASN caseload?
Response: An ASN caseload is dependent on the complexity of the cases. The contractors will determine what their caseloads will be while ensuring ACD requirements are met.

142. What is the PCM's role going to be like now that there is an ASN involved?

Response: The Primary Care Manager (PCM) is responsible for diagnosing, referring, and managing the care. The ASN is providing the intensive care management services that aid in coordination of care and connecting families with resources.

143. Doesn't the ASN overlap with the EFMP role?

Response: No. EFMP is a Service-owned program (not medical) that has 3 purposes: identification/enrollment, assignment coordination, support to help families identify services/programs. These EFMP services are outside of Private Sector Care/the TRICARE benefit. The ASN will be specific to the TRICARE benefit and will be someone that can help the families connect all the pieces. The scope of collaboration, advocacy, and oversight is more comprehensive than the EFMP coordinator.

144. Can the ASN perform the outcome measures?

Response: This is a contractor process question. Please check your contractor's website or contact your contractor for additional details.

145. When requests for authorization are submitted, do those go to the ASN?

Response: This is a contractor process question. Please check your contractor's website or contact your contractor for additional details.

146. Will the ASN have any role in whether a patient is approved for services (i.e., and clinical decision making)?

Response: No. The ASN's primary role is to collaborate and oversee the assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes. For approval of services, the policy requires that a clinical necessity review is completed by a qualified clinical reviewer (BCBA or like-specialty) separate from the ASN.

147. There is a concern that an ASN, someone who is not directly involved in the clinical care, would have a key role in setting up, signing off, and approving treatment plans. Why are you requiring another approval?

Response: The ASN is not responsible for "setting up, signing off, or approving treatment plans." For approval of services, the policy requires that a clinical necessity review is completed by a qualified clinical reviewer (BCBA or like-specialty) separate from the ASN.

148. When do we notify the ASN if the client is moving?

Response: As the ASN is engaging with the family, they should already be informed by the family directly about their transitioning plans. However, the authorized ABA supervisor may provide this information as soon as they become aware of the pending move.

149. In paragraph 6.1.2, it says that contact shall be made prior to any ABA services being authorized. Why would you hold up care while awaiting a response from the parent?

Response: There should be no delay in accessing care as a result of the ASN assignment, pending the family engages timely.

150. Are we going to have ASN services in Europe?
Response: At this time, the ASN role is available in only the East and West Region contractors.

151. Is a "non-response" from a family considered the same thing as "declining" an ASN?
Response: It is possible that a non-response, and subsequent attempts, at initial contact could be considered a decline of ASN services.

152. If the family is not doing their part, how will the provider be notified, especially if services need to be paused?
Response: This is a contractor process question. Please check your contractor's website or contact your contractor for additional details.

Comprehensive Care Plan (CCP)

153. The manual states that the "ASN shall complete the CCP within 90 calendar days of the family being assigned an ASN." From a practical standpoint, what benefit is a 3-month delay in start services are a child with ASD and the family?
Response: There will be no delay in beginning the ABA assessment and treatment process as a result of the ASN and the CCP development. The ASN and family have up to 90 days to complete the first CCP.

154. Will we be paid for services provided while the CCP is being completed, in the event that the plan is not actually completed in 90 days?
Response: As long as there is an active authorization in place, services may be reimbursable. However, if a CCP is not completed within 90 days, the authorization for ABA services will terminate and service rendered after the termination date will not be reimbursed.

155. Will a family already participating in the ACD have a CCP even though they don't have an ASN?
Response: No. The assignment of an ASN triggers the completion of a CCP.

156. What happens if the CCP discharge criteria conflicts with the ABA provider's criteria?
Response: The CCP is not a treatment plan. Rather, the Comprehensive Care Plan sets client goals, identifies activities or action steps needed to achieve these goals, expected dates for each action step, and any resources or support needed to complete the Care Plan. Each action step on the Care Plan should list a responsible party, target date, outcome, and outcome date. The plan may incorporate care or services from various entities i.e.,

behavioral health, nursing, and other specialist and allied health professional plans as needed as well as community services, school service, etc.

157. Will a copy of the CCP be provided to all treating providers (3)

Response: *Yes, for the providers that are involved in the care of ASD for that beneficiary.*

158. Will the CCP be updated before or after a new authorization is issued?

Response: *The contractor will update the CCP at least once every six months.*

159. How do you resolve an unfinished CCP because there are recommended outcome measures that are not clinically known or likely and the BCBA does not agree? Could this result in a delay?

Response: *The outcome measures are collected by the contractor and part of the CCP which is completed by the ASN. While the BCBA is one provider that may be authorized to complete the outcome measures, there are other eligible provider types who can be authorized to complete the outcome measures in order to meet the completion timeline. Complete and valid outcome measures must be received by the contractor to authorize services but their integration into the CCP is not a requirement for authorization. The integration of the outcome measures in the CCP would be expected for each CCP update.*

160. If the CCP is not completed within 90 days, will the ABA provider be penalized by the services being placed on hold?

Response: *If a CCP is not completed within 90 days, the authorization for ABA services will terminate and service rendered after the termination date will not be reimbursed. If there is a gap, authorizations will not be backdated.*

161. If the CCP is not completed by 90 days and care is suspended, how will the ABA provider be notified to hold services?

Response: *An update to an authorization's service dates would trigger an amendment to the original approval letter and be sent to the provider through the standard process of communication for authorizations.*

162. What recourse will families have if the ASN fails to complete the CCP within 90 days?

Response: *The ASN is designed to assist the family, therefore, the ASN will not be the reason that a CCP is not completed within 90 days.*

163. Can DHA clarify when ABA services are permitted to begin and why it has chosen to distinguish ABA services from other services?

Response: *DHA is revising paragraph 6.2.4 to address this confusion.*

Reimbursement rates

164. In the updated manual, it appears to state that the BT rate will be $50.00/hour which is a change from the current rate in our region. Will the regional rates still apply or are the rates being changed a flat rate?

Response: The reimbursement rates listed in the TOM are the floor rates, and per paragraph 8.11.7.1, rates are adjusted based on the geographic localities. Please see www.health.mil/rates for the rate sheet.

165. For the assistant level billing noted on the allowable charges rate sheet, is that only for the assistant level staff or can they have a master's degree and be able to bill those codes at those rates?

Response: Reimbursement rates are tied to the level (taxonomy) to which the provider is authorized. If you are authorized as an assistant, then you will be reimbursed at that assistant rate regardless of your educational level.

166. Why am I finding different rate for the group psychotherapy codes from what has been published for the group parent training/group ABA codes?

Response: The reimbursement rate CPT code 90853 is different than the CPT codes for ABA services because CPT code 90853 is defined as "Group psychotherapy including interpersonal interactions and support with several patients; typically 45 to 60 minutes in length." CPT code 97157/97158 are 15 minute units, not 45-60 minutes. The unit rate was divided to mirror the 45-60 min rate.

167. Why are the Medicaid rates for 97157 and 97158 not being used?

Response: By way of background, TRICARE as a general rule follows Medicare's reimbursement methodology. In the case of the reimbursement rates for the ACD, DHA would follow Medicare's approach; however Medicare does not reimburse for any of the ABA services (i.e. 97151, 97153, 97155, or 97156, 97157, or 97158). Therefore, DHA would then look to Medicaid. However, not enough Medicaid data was available for these two codes.

168. Will the new provider rates be published on 5/1?

Response: Yes. The 2021 rates are available at www.health.mil/rates.

169. I recently relocated my office. Where do I find the place to look up providing areas by zip code?

Response: Please see this link (https://health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement/CMAC-Rates/Cross-Code-Lookup) to enter your zip code and obtain your locality code.

170. What is the reimbursement rate for outcome measures?

Response: All reimbursement rates are determined by the localities. Outcome measures, when prior authorized (effective August 1, 2021), will be reimbursed for 1 unit per measures

under 97151. With this policy change, please note that the PDDBI CPT Code (T1023) was realigned to CPT code 97151 and included in the 32 and 24 units for initial assessment and reassessment, respectively. Also note, exiting authorizations prior to 8/1 for outcome measures authorized for T1023 can run their course.

<u>Outcome measures – General questions</u>

171. If the TRICARE providers aren't able to complete outcome measures in 2 years, why would it change to every one year?

<u>Response:</u> DHA revised the entire requirement to make it easier for these measures to be completed timely including who may be eligible to complete the measures and removal of the referral requirement.

172. Will the BCBA be responsible for only the PDDBI or will they also be responsible for the other 3 outcome measures?

<u>Response:</u> The authorized ABA supervisor is responsible for only the PDDBI. The other 3 outcome measures may be prior-authorized to the authorized ABA supervisor, but not necessarily. Please check your authorization, your contractor's website, or contact your contactor before completing the Vineland, SRS, or parent stress measure.

173. Are outcome measures other than the PDDBI still first the responsibility of the diagnosing provider/PCM?

<u>Response:</u> Not necessarily. The diagnosing provider may administer these measures at the diagnosing appointment, but are not required to do so.

174. Is it preferred for ABA providers or doctors at the MTF to administer the Vineland/SRS?

<u>Response:</u> The preference is to complete timely and valid outcome measures. The contractor is responsible for ensuring the administration of the outcome measures.

175. How will the 2-year chronological referral alignment impact outcome measures due dates?

<u>Response:</u> The two-year chronological referral timeline alignment is separate from the outcome measures timeline. Please check your authorizations, your contractor's website, or contact your contactor for additional questions.

176. Are all outcome measures included in CPT Code 97151?

<u>Response:</u> Outcome measures must be pre-authorized. If authorized to a BCBA, then the appropriate CPT code would be one unit of 97151 for authorization requests submitted on or after August 1, 2021 per measure per occurrence.

177. What safeguards are in place that beneficiaries will not lose access to care if there are no available providers to complete the outcome measures?

Response: *Outcome measures are not a new requirement. With the policy change, the contractors are required to identify providers who can complete the requirements.*

178. Some states do not allow BCBAs to complete psychological assessments. How do you know if a BCBA is able to complete the measures?

Response: *For the standardized assessment tools required (PDDBI, Vineland, SRS, SIPA, PSI), the publishers require qualifications for completing measures. These can be found on the publisher's websites. BCBAs are responsible for working within their scope of expertise and their governing licensure/credentialing boards.*

179. Can outcome measures be completed by a BCBA?

Response: *Each of the publishers have set a minimum level of competence to render all assessment tools. Each of the measures selected may allow BCBAs to be eligible, but prior authorization is required.*

180. If the family is struggling to get the outcome measures completed by the PCM, will that pause ABA services if the 90-day limit has been reached?

Response: *Although the TRICARE authorized referring and diagnosing providers are eligible to complete the outcome measures (except the PDDBI), it is unlikely that all 3 outcome measures would be completed by a PCM. The family should reach out to the contractor who will identify a provider who can be authorized to complete the outcome measures. Please remember that with this policy change, no referral is required, however, prior authorization is required.*

181. It is unclear if the BCBA is "required" to complete these outcome measures.

Response: *The BCBA is "required" to complete only the PDDBI. However, as an eligible provider, the BCBA may be approved to complete other outcome measures.*

182. Whose responsibility is it to get the outcome measures done?

Response: *The contractors are responsible for ensuring the outcome measures are completed by an eligible provider.*

183. Will TRICARE provide a copy of the outcome measures forms to the ABA provider if these are required and if it is not one that the provider normally uses?

Response: *No. Outcome measures are purchased by the administering provider under their license or certification. DHA cannot purchase measures and hand them out for completion.*

184. Does this mean that we no longer have to do the PDDBI?

Response: *No. The BCBA is still required to complete the PDDBI.*

185. Will families be required to complete all of the measures listed?

Response: *Yes, but they are all age based. If the beneficiary's age is outside the range of the measure, they will be exempt. All outcome measures are required at different periods throughout ABA services.*

186. It was mentioned that outcome measures must be completed prior to beginning ABA treatment services. Does this include ABA assessment services too?

Response: *The initial ABA assessment must be completed in order to develop a treatment plan. Then the treatment plan is submitted for review and subsequent authorization for ABA treatment services. The treatment plan should identify goals that are informed by these outcome measures and other updates.*

187. If a child is too young to administer one of the required tests at initiation of services, will services still be authorized so long as the required test is administered and submitted at the earliest availability per the test norms?

Response: *Yes. All measures must be rendered to only eligible beneficiaries. If a beneficiary is outside of the measure assessment window, they then are exempt.*

188. What if the authorized ABA supervisor does not the meet the definition in the PDDBI to complete the teacher form of the PDDBI?

Response: *A BCBA is the responsible party for all treatment plans in which they supervise. They should absolutely have enough contact with the family and the beneficiary to be able to complete the outcome measure. If they do not, then the BCBA does not have sufficient oversight of the program and should notify the contractor that they are not able to oversee the treatment plan.*

189. Do you want only the scores of the full report?

Response: *Per paragraph 8.6.4, "submission of all outcome measure results must include the full publisher print report…"*

Documentation

190. When do the new documentation standards begin?

Response: *All new additions to the documentation requirements, i.e., group notes, comorbid conditions paragraphs, will be effective 8/1/21.*

191. How do we document parent training (CPT cod 97156)? What information needs to be included?

Response: *Please see paragraph 8.7.2 for progress note documentation requirements.*

192. Will session notes prior to 4/16/21 be grandfathered and accepted as these distinctions were never made or clarified before this training in regards to techniques and session locations?

Response: *Guidance regarding documentation of techniques implemented during the session, this is not a new requirement. Regarding documenting the location of service in the session*

note, which will become effective 8/1/21. Please note that Place of Service has always been a requirement on the claim form.

193. During the webinar, there was a recommendation about when a note should be completed. What was that recommendation?

<u>Response:</u> Notes should be completed as soon as possible. In the webinar, the suggestion was regarding no later than 72 hours after the session. However, with the high frequency of sessions and providers rendering ABA services to beneficiaries, it is recommended that the provider immediately complete the session note in order to retain the most accurate information.

194. Can TRICARE provide clarification regarding the format expected in documentation for the "patient's degree of progress?" Is TRICARE looking for a percentages, etc.?

<u>Response:</u> The expected format is a narrative statement summarizing progress towards each of the treatment goals.

195. Can TRICARE provide clarification regarding "clinical status?"

<u>Response:</u> The clinical status of the beneficiary is the specific, observable and measurable behavior displayed by the beneficiary at the beginning of treatment that indicate his/her readiness for learning, presence of antecedents to target behaviors and setting events. These items typically influence the application of ABA principles throughout the session, including the frequency and type of preference assessments, behavior momentum, type of teaching techniques utilized, modifications to the environment, and possible impact on performance. The diagnostic criteria for autism spectrum disorder, such as communication, socialization and repetitive behavior, are not sufficient for clinical status.

196. Paragraph 8.7.1.1 says that the treatment plan should include the date of the initial ABA assessment and the initial ABA TP were completed. Is this asking for two separate dates? These things tend to overlap.

<u>Response:</u> Yes, it is asking for two separate dates, but we also understand it may be the same date.

197. What is meant by "accurately documenting your activities?"

<u>Response:</u> All medical records should document what occurred during the session. Examples include, accurately documenting session time, rendering provider, interventions delivered, etc.

<u>Place of Service (PoS)</u>

198. If a beneficiary receives services in more than one approved location in the same day, should there be a progress note for each location or can there be one? And should this be billed with two line items and two different locations or should this be billed as one line item for the total time using the location where the most time was spent?

Response: *If you are transporting beneficiaries, the time in between sessions is not billable. Therefore, you have 2 notes to complete, one for each location where services are rendered resulting in two different line items for the two different locations in the claim.*

199. When ABA services are provided in an ABA provider's office, should the billing location be office or clinic?

Response: *ABA providers rendering services in the office/clinic setting should use only PoS 11.*

200. When does the change regarding Place of Service 99 take effect? Is there a time when this requires prior approval?

Response: *Please refer to your contractor for additional guidance on the use of PoS 99. Additionally, all ABA services require prior approval regardless of place of service.*

201. When treatment in the school setting has been approved, and beneficiary attends online school at home, is the billing location considered school or home?

Response: *For ABA services authorized in the school setting prior to 5/1/21, and are now rendered at home due to COVID stay at home orders, the Place of Service is home. ABA services still must be clinically appropriate.*

202. Seeking clarification regarding when it is approved to use Place of Service 11 (school) is approved. Paragraph 8.10.11 excludes school settings and paragraph 8.11.3 has school in the parenthetical clause.

Response: *Place of Service 11 is the ABA office/clinic setting. Place of Service 3 is the school setting. New authorizations issued on or after 5/1/21 shall not authorize BTs in the school setting (PoS 3). However, should authorized ABA supervisor services be authorized for targeted/time-limited, clinically appropriate ABA services in the school setting, PoS 3 may be used.*

203. Regarding documentation of billing for two services at the same time (BT with client and the BCBA with the parent), how should that be documented in notes and claims? There would be two separate claims and two separate providers, but the same locations.

Response: *If both CPT code 97153 and 97156 are rendered in the same Place of Service (i.e., home – 12), then the two claim lines would in fact note "12" in the form. Additionally, the claims lines should identify the rendering provider corresponding to the session. Also, the session note documentation should contain the level of detail regarding specific location and two separate session notes should be completed.*