

# Questions and Answers

## Autism Roundtable #7

October 19, 2016

Please submit all future questions regarding the Comprehensive Autism Care Demonstration (ACD) to the following email address: dha.ncr.tricare-hp.mbx.acd@mail.mil

### Authorizations

Q: What is the role of the Authorized Corporate Service Provider (ACSP) in getting the Physician-Primary Care Manager (P-PCM) referral? Are we still not allowed to submit our reports until there is a referral in place? When will this requirement change?

A: Effective August 11, 2016, through a common letter to the TRICARE regional contractors, all authorized Applied Behavior Analysis (ABA) supervisors, to include ACSPs, are authorized one additional 0359T without the P-PCM referral. The November 29, 2016 manual change removed the P-PCM referral at the six-month mark and requires only a referral at the every two-year mark to coincide with the Periodic ABA Program Review.

Q: In light of the removal of the P-PCM referral at the every six-month authorization period, how do we request a new 0359T and authorization?

A: As of August 11, 2016, at the end of every authorization period, a request for continued services (a new authorization period), to include the specific Current Procedural Terminology (CPT) codes and the requested number of hours, is required. The authorized ABA supervisor will need to submit an updated assessment and treatment plan (to include a request for the next 0359T) to your TRICARE regional contractor before the next authorization is issued.

Q: Board Certified Behavior Analysts (BCBAs) are recommending certain levels of care based on their assessments of the child. No information has been provided regarding how the contractors are deeming the number of hours that would be appropriate for a beneficiary. There is no clear process in place for appealing these issues and no objective criteria stated as to how these decisions are being made. Please provide guidance.

A: As a general matter, TRICARE regional contractors are staffed with qualified experts who follow TRICARE program requirements and health care industry best practices to determine the appropriateness of care for each beneficiary's condition, including the process for assessing the appropriateness, frequency, and amount of ABA services to authorize. The Defense Health Agency (DHA) does not dictate the specific number of hours to authorize as that level of benefit administration is within the purview of the contractors based on the facts of each case as documented by the providers and evaluated by the regional contractors using

their professional judgment. TRICARE Appeals and Hearings processes are set forth in TRICARE Operations Manual (TOM) Chapter 12. Please see the following link for the TRICARE Fact Sheet for filing an appeal: <http://www.tricare.mil/ContactUs/FileComplaint>.

Q: The TOM explicitly states that the 2 year review should not be used to hold access to care. Additionally, no clear information was provided to BCBAs about the 2 year review and what was required. Notification about the review has come only after a continuing authorization has been requested which leaves only a few days to even provide the information. Please clarify the two year review requirement.

A: ABA supervisors need only to submit the reassessment and updated treatment plan to the TRICARE regional contractors every six months for continued authorization for ABA. The every two year review (the Periodic ABA Program Review) enables the TRICARE regional contractors to assess treatment progress/appropriateness, to identify beneficiaries who are not making progress/not receiving appropriate services, and then engage the provider to address those issues. If an ABA provider fails to submit required documents on time, they place their patient at risk of denial of continued authorization. The two year review is completed by the specialized ASD diagnosing provider and requires the following: the ADOS-2 for symptom severity; and the Vineland-3 for adaptive behavior functioning; and a Wechsler Intelligence scale (WPPSI-IV, WISC-V, or WAIS-4) or the TONI-4 for intellectual/cognitive functioning. With the November 29, 2016 manual revision, effective date January 1, 2017, documentation of the specified outcomes measures will be required at the two year mark.

Q: In efforts to help notify families that their two year review will be coming up, how can we find out what that date is?

A: Please contact your TRICARE regional contractor to obtain the two year review date.

Q: Can providers get a copy of the "common letter" regarding ACD changes that are now in effect?

A: The contents of the common letter, effective August 11, 2016, are as follows:

“It is anticipated that there will be a TRICARE Operations Manual change issued no later than October 1, 2016 with a 30 day implementation period, which deletes the requirement for a new PCM referral every six month in accordance with paragraph 8.1.2.4 of TOM Chapter 18, Section 18.

To ensure continuity of care for all authorized ACD participants, this letter shall serve as interim authorization that existing authorizations referenced above for care under ACD are extended and authorized to include the addition of a reassessment code (0359T) when the PCM has failed to submit timely referrals every six months. To maintain quality of care, however, the authorized ABA supervisor providing the ABA services to the beneficiary shall

continue to provide the contractor with the initial ABA Treatment Plan (TP) and an ABA TP update before the six month authorization expires IAW existing ACD policy.

We have found that failure to submit timely reassessment referrals every six months is primarily an issue in locations where timely appointments with P-PCM or specialized ASD diagnosing providers may not be readily available. This may lead to a break in care that is not beneficial for a beneficiary's need for continuity of treatment.”

### **Behavior Technicians**

Q: When TRICARE says it is eliminating education requirements, is it also eliminating experience requirements – e.g., the 500 hours of experience for Behavior Technicians (BTs) who are high school graduates?

A: Correct. With the implementation of the BT certification requirement, TRICARE will rely on the certification standards of the three accrediting bodies (*i.e.*, the Behavior Analyst Certification Board (BACB), Behavior Intervention Certification Counsel, and the Qualified Applied Behavior Analysis certification board) to ensure that each BT has met the minimum requirements for education and training. The TRICARE education and experience requirements for BTs has been deleted.

Q: Is there a way for us to list ourselves as being open to hiring/ working with military spouses as Behavior Technicians?

A: DHA recommends connecting with the local military installation family service center, command ombudsman, and/or spouse employment assistance office.

Q: Please explain the different BT certification deadlines: 12/31/15; 12/31/16. Can BT's be billing right now without the BT certification?

A: As of January 1, 2016, all newly hired BTs approved to participate in the ACD were required to possess BT certification and contractor approval prior to being eligible for payment of ABA services under the ACD. The 12/31/16 deadline refers to all legacy BTs (*i.e.*, those hired prior to January 1, 2016) who did not possess a BT certification from one of the three approved certification bodies. As of 1/1/17, all BTs approved under the ACD must possess BT certification prior to rendering ABA services under the ACD. All claims submitted for non-certified BTs will be denied.

Q: If the BTs have all the requirements (BT certification and the Basic Life Support (BLS) certificate), how can the process of adding BTs to TRICARE's roster as 1:1 paraprofessionals be expedited?

A: While a consistent implementation process is being refined by the TRICARE regional contractors, a provisional status for BTs under the ACD has been approved by senior

leadership. Provisional status is defined as the period of time, not to exceed 90 days, after which the BT has completed all education and training requirements, has passed the BT certification examination, has completed BLS/Cardiopulmonary resuscitation (CPR) equivalent certification, and has submitted a complete application packet to the TRICARE regional contractor. The TRICARE regional contractor may then grant provisional status while they verify all elements of the application. The BT may be eligible to render services once notified by the TRICARE regional contractor that their provisional status has been approved.

### **CPT Codes**

Q: Please clarify for CPT code 0368T whether or not a parent or client needs to be present? It is clinically necessary to have these meetings to ensure that each BT is on the same page (in between supervisions), that everyone is implementing procedures the same way, and that they understand any amendments to the behavior plan/program to ensure fidelity of implementation.

A: The beneficiary needs to be present; the presence of the parent is encouraged but not required. All of the ABA CPT codes, except 0370T (Family Adaptive Behavior Treatment Guidance), require the beneficiary to be present. For CPT code 0368T/0369T (Adaptive Behavior Treatment by Protocol Modification), parental participation is optional. However, their involvement is encouraged. As described in the code, protocol modification requires demonstration of the treatment plan. The code is only reimbursable as a direct service, meaning the beneficiary is present. Otherwise, this would be defined as indirect service which is excluded from reimbursement.

Q: Providers are inquiring about how they will bill for indirect services or for those that do not include the beneficiary. For example, CPT code 0368T/0369T, which can only be billed when the beneficiary is present. Some providers believe that indirect services are not included in the total CPT code. Please review the American Medical Association (AMA) CPT coding structure.

A: As defined by AMA, each CPT code contains 3 parts: pre-service, intra-service, and post-service. According to AMA, “the pre-service work includes preparing to see the patient, reviewing records, and communicating with other professionals. The intra-service work includes the work provided while the physician or qualified healthcare professional (in this case the authorized ABA supervisor) is with the patient and/or family. The post-service work includes arranging for further services; reviewing results of studies; and communicating further with the patient, family, and other professionals, including written reports” (Beck and Margolin, 2007). Therefore, all services related to that procedure code are already incorporated into the code and cannot be billed separately. Also, by law (32 Code of Federal Regulations (CFR) 199.4(c)(1) and (g), and TRICARE Reimbursement Manual, Chapter 1, Section 19), TRICARE is not permitted to reimburse for separate indirect or administrative expenses.

Q: With autism being a social disorder among other deficits, why isn't there a code to use for social skills?

A: The ACD covers ABA services delivered individually during one-to-one sessions with each TRICARE beneficiary diagnosed with ASD. Group ABA interventions have never been covered out of quality concerns that the ACD must ensure the highest quality ABA services are delivered to each beneficiary. The research evidence that group ABA interventions are effective is insufficient to include group ABA in the ACD. Requiring ABA interventions to be delivered individually, rather than in a group format, helps to ensure that each beneficiary receives the individual attention they deserve. While there is no separate Category III ABA CPT code for social skills training delivered individually, the domain of "social communication" is permitted as a treatment goal under the one-to-one setting of 0364T/0365T (Adaptive Behavior Treatment by Protocol).

Q: Can CPT codes 0360T/0361T (Observational Behavioral Follow-Up Assessment – Supervised Fieldwork), 0368T/0369T (Adaptive Behavior Treatment by Protocol Modification), and 0370T (Family Adaptive Behavior Treatment Guidance) be billed on the same day?

A: Yes. However, each CPT code must have separate and specific session notes that clearly identify the time and date of service, session notes, and specifically identify the providers involved in each session.

Q: The TOM states that billing of the assessment code 0359T does not have to be more than 6 months though all our assessments codes with billing/PGBA (Palmetto Government Benefits Administrator) are still being denied if they were billed with less than a 6 month 1 day window. Can you please clarify why this is happening through PGBA?

A: The language was modified in the October 1, 2015 manual revision (manual change 154) to reflect the allowance of one 0359T (ABA Assessment and ABA Treatment Plan) per authorization period, except for the initial authorization period.

### **Education/Academic Goals**

Q: The previous version of the ACD manual, TOM Chapter 18, Section 18, change 174, does not mention prohibiting academic/educational goals. However, at the October Round Table, an announcement was made that education and academic goals are not authorized. Will the new policy update clearly define education/academic goals? How can DHA evaluate outcomes if these critical components are excluded?

A: To be clear, TRICARE benefits must be authorized to be cost-shared; the rule is not that services may be cost-shared unless prohibited. Filing claims for unauthorized services constitutes grounds for recoupment and potential investigation for fraud and penalties under the Federal False Claims Act and other authorities. The newly published manual revision

lists academic and educational goals in the exclusions section. These terms are not specifically defined as it is the responsibility of the contractors to use best practices to determine the application of the policy. Educational benefits are excluded from coverage by regulation: 32 CFR 199.4(g)(42) "Education or training. Self-help, academic education or vocational training services and supplies, unless the provisions of Sec. 199.4, paragraph (b)(1)(v) relating to general or special education, apply." and 32 CFR 199.4(b)(1)(v) "General or special education not covered. Services and supplies related to the provision of either regular or special education generally are not covered. Such exclusion applies whether a separate charge is made for education or whether it is included as a part of an overall combined daily charge of an institution. In the latter instance, that portion of the overall combined daily charge related to education must be determined, based on the allowable costs of the educational component, and deleted from the institution's charges before CHAMPUS benefits can be extended." The only exception is when appropriate ABA services that are authorized under the ACD are not available from or not payable by the cognizant public entity – but only such ABA as is determined by the TRICARE regional contractor as clinically appropriate, and not merely educational in nature.

Outcomes of the ACD are evaluating the efficacy of ABA services for clinically appropriate goals. Educational/academic targets are outside the scope of this demonstration.

Q: While assessments like the Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP) and the Assessment of Basic Language and Learning Skills – Revised (ABLLS-R) are recommended to be used in the TOM, case managers are denying goals derived from these results they term as academic/educational. ABA treatment, which is distinctly different from special education, is designed to facilitate skill deficits associated with meeting all goals and objectives that work towards each child's total independence. Not allowing these goals to be addressed hampers the way ABA has been designed to be used. How does DHA plan to address this issue?

A: The VB-MAPP and ABLLS-R will be removed from the ACD in the upcoming manual revision. Treatment plan goals should be based on the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria. Therefore, distinct academic or educational goals are not considered clinically appropriate and are excluded from coverage. A beneficiary may require educational or academic support, but that is not the scope of the ACD, which provides health benefits not educational services. ABA providers should be working with schools and other educational and social service resources concerning ABA needed to address purely academic and educational goals.

Q: One rationale TRICARE gives for requesting Individualized Education Programs (IEPs) with Treatment Plans is that TRICARE is reviewing plans to ensure that ABA goals do not overlap with goals on the IEP or that ABA goals are not "too educational." With that, for those beneficiaries that have IEPs and also receive Occupational (OT) , Speech and language

pathology (SLP), and/or physical therapy (PT) under TRICARE, are these providers required to send in IEPs with each update to ensure their goals are not "too educational" and/or do not overlap with educational OT/SLP/PT goals? If they are not required, then what is the justification if for ABA?

A: Generally speaking, OT, PT, and SLP services are not educational in nature and do not run the same risk as being an uncovered benefit in an educational setting. Therefore, no IEP is required. However, if TRICARE were to provide these services in the school setting, the IEP would be required to ensure that goals do not overlap or are educational/academic in nature.

### **Every 6 month reassessment**

Q: The VB-MAPP is not appropriate for ALL children. The VB-MAPP covers milestones up to 48 months. What are we supposed to use for older clients or clients with mainly social or cognitive deficits? What use will that play in effective measurement of ACD outcomes? Is there any option to use a different standardized assessment for older clients with different needs? It is recommended that DHA provide a few assessment options based on the child's age.

A: DHA received feedback regarding the appropriateness of the VB-MAPP as the assessment tool to be used at the 6-months reassessment period. Several recommendations were proposed. Per the recommendation provided at the round table, DHA removed the VB-MAPP from the requirement and replaced that assessment tool with the PDDBI (Pervasive Developmental Disabilities Behavior Inventory).

Q: If the BCBA is required to complete the every 6 months new reassessment tool, will the reimbursement rate for 0359T increase considering these added costs of time paid for a provider to conduct this assessment every 6 months?

A: The CPT code 0359T (ABA Assessment and ABA Treatment Plan) is an untimed code, per AMA direction, and the rate is set regardless of the amount of time it takes to complete that reassessment. The actions in this CPT code are no different in the revised manual change, and the recommendation of one standardized assessment tool does not change that requirement. The every 6 month reassessment will remain the responsibility of the BCBA. However, the assessment tool has been revised from the VB-MAPP to the PDDBI. This assessment tool is a questionnaire that will be completed by the parents and teachers (if necessary), and requires no additional assessment face-to-face time by the BCBA. The BCBA will be responsible for generating the computer based report.

Q: Will treatment goals and graphs have to be based off the assessment items of the selected assessment tool?

A: To justify TRICARE cost-sharing under the ACD, long-term goals and objectives must be based on the DSM-5 domain deficits. The short-term goals and objectives need to be the broken down, measureable, and objective elements must be present for each long-term goal and objective. Assessment tools may be used to support goal development, but an assessment tool may not be the basis for any treatment plan.

Q: The VB-MAPP is not appropriate for ALL children. What about children that are high functioning and may have the majority of those skills but need assistance in daily living skills or job skills?

A: Daily living skills and vocational skills are excluded from coverage under the ACD as well as excluded in TRICARE regulation under 32 CFR 199.4 (g)(7), the exclusion for custodial care (the exclusion for activities of daily living), and 32 CFR 199.4 (g)(39) and (42), the exclusion for vocational skills. There should be no treatment goals approved for these areas as these are considered non-medical services. TRICARE is authorized to cost-share health benefits, not educational services. ABA providers should be working with schools and other educational and social service resources concerning ABA needed to address goals related to assistance in daily living or job skills.

### **IEP/School**

Q: In the spirit of good teamwork, providers are telling schools what goals they are working on. Some schools are adding those goals into the IEP. Then, case managers are denying such goals because they are appearing on the IEP. This seems counterproductive to the teamwork efforts. If a child requires those supports, why is TRICARE denying those goals?

A: In the November 29, 2016 manual revision, the IEP submission requirement was removed. However, if a beneficiary requests services in the school setting, the parents must submit the entire IEP document for contractor review. If the contractor identifies a treatment plan goal that is also on the IEP or non-public school equivalent, then that in-school support will be denied because the school has deemed that target as a need, and by law, are required to provide that support. TRICARE would not reimburse for that service. TRICARE is authorized to cost-share health benefits not educational services.

Q: Can the referring provider provide language with the ABA referral that they "have reviewed the patient's IEP and the referred services are not duplicating services provided by TRICARE?"

A: No. If school services are requested for medically necessary ABA services under the ACD, then the entire IEP must be submitted by the parents to the contractor for review and approval of services.

Q: It was announced at the October Round Table that a child cannot be seen in a public school setting, but it was unclear about if they can continue to be seen in the private school setting. Can you please clarify?

A: After much feedback, the manual revision does not explicitly exclude “school” settings. Instead, the revision states that no school settings (public or non-public, to include private schools) will be approved for TRICARE-funded ABA services unless an IEP or non-public school equivalent is submitted by the parents and subsequently reviewed by the contractor to determine if goals submitted are medically necessary and appropriate, and are not educational or academic.

Q: When will IEP submission no longer be required?

A: TRICARE revised the IEP requirements in the manual revision. The effective date is January 1, 2017.

Q: It was mentioned that IEPs will no longer be required; however, this is at the cost of services being provided in public schools. Almost no school provides ABA, and schools do not provide medically necessary treatment for autism. Our services are needed to assist the teacher and ensure the behaviors do not interfere with their education. Would TRICARE be willing to reconsider the decision if parents wish to submit the IEP?

A: DHA received several comments regarding in-school ABA services and the removal of the IEP requirement. The manual change revised the requirement so that in-school services will continue to be denied unless the IEP (or equivalent for non-public school placements such as private schools) is submitted by the parents in order for the contractor to make an appropriate determination for approved in-school ABA services. If a teacher requires assistance with a child's behavior in the classroom, the school is obligated to provide that resource.

Q: Why did TRICARE decide to eliminate schools as a location for ABA services?

A: In addition to parental refusal to submit IEPs, DHA received several questions regarding non-approved ABA services in the school setting. After reviews of treatment plans and feedback from the contractors' annual audits, a significant number of progress notes documented non-covered services such as personal care attendant, non-ABA services, and other non-approved treatment goals. Using the CPT codes to bill for these services or others considered "tuition" is improper. In light of these growing problems, DHA has removed the IEP requirement and excluded in-school services. However, if a parent requests in-school services, the entire IEP or non-public school equivalent document must be submitted by the parent for contractor review for final determination of approved in-school ABA services.

Q: In the public school setting, the school has limited resources for autism services and does not have support staff to meet the needs of this population. Therefore, parents are opting to send their children to a private school where the ABA provider can support the beneficiary's needs. In a private school setting, the ABA providers do not provide special education needs. One of our goals for these clients is to assist in learning school-based behaviors. Goals that are targeted on treatment plans are not academic in nature, but address evident deficits based on the DSM-5 characteristics of autism that are presented by the client. Therapy focuses on decreasing behavioral excess, increasing appropriate behaviors, and facilitating independent functioning. Since this is not a public school environment, would this private school setting be an approved environment for service delivery? Will private school students still be eligible for reimbursement?

A: DHA received several comments regarding in-school ABA services. The manual change has revised the requirement so that in-school services will continue to be denied unless the IEP (or equivalent for non-public school placements such as private schools) is submitted by the parents in order for the contractor to make an appropriate determination. While DHA appreciates the adherence to clinically appropriate goals on a treatment plan not being educational or academic, many treatment plans have been identified as providing educational and/or academic goals such as math and sentence structure development. Therefore, narrowing the definition of clinically appropriate services was warranted. ABA services in a private school setting may be reimbursed only if an IEP equivalent document has been submitted to the contractor and reviewed for appropriateness.

Q: If a child is unable to remain in school due to a lack of ABA services in the school setting, how will that impact the child, family, and outcomes?

A: Under IDEA, if a child is unable to function independently in school, the school holds primary responsibility to provide the necessary services. The ACD provides only clinically appropriate services, not academic/educational, in-school support. The ACD outcomes are assessing clinically appropriate treatment goals and do not address non-educational/academic goals. ABA providers should be working with schools and other educational and social service resources concerning ABA needed to address academic and educational goals, and the obligations of the public schools regarding private placements as required by law when the school system cannot meet the academic and educational needs of a student.

Q: In the instances where ABA services in the school are considered medically necessary, could the authorized ABA supervisor submit the IEP and have the contractor review the document for approval? Is it possible to limit the information so that the parents do not need to release the entire IEP?

A: It was announced in the October round table that the IEP will no longer be required and that ABA services in the school setting will no longer be approved. However, after

significant feedback and review, DHA may permit clinically appropriate ABA services in the school setting where the goals have not been identified in the beneficiary's IEP or equivalent for non-public school settings. However, the entire IEP must be submitted by the parents to the contractor for review and approval of services by the contractor. Submission of the IEP for ABA services authorized under the ACD in a school setting is essential to determining TRICARE's authority to cost-share for the services and prevents fraud.

### **Other**

Q: Would DHA consider making remote parent training (CPT 0370T) via real time means acceptable?

A: DHA will take this request for action. The current language in the TOM excludes all remote ABA activity except for remote supervision (TOM, Chapter 18, Section 18, Paragraph 19.0). DHA will review the current state of the literature regarding remote parent training to provide guidance on a clinically appropriate determination.

Q: The background and training of ABA providers does not include content relevant to the ACD's requirements for documentation. Specifically, the content of the session, narratives of interventions and responses, and progress summaries are not addressed in the training requirements prescribed by the BACB or other credentialing agencies and training programs. Rather, ABA providers document sessions in tabular or graphical format so as to measure time and frequency of events. Thus, it is common for ABA providers to submit progress notes in a manner consistent with their training, which is at odds with the TOM requirements. Is there any plan to revise the TOM requirements for ABA session documentation?

A: The design of the ACD is to administer this demonstration as close to a medical benefit under the TRICARE Basic program requirements as possible. As part of the health care industry, documentation of session encounters is one element that composes a medical record. At a minimum, ABA medical record documentation must comply with the requirements of TRICARE Policy Manual (TPM) Chapter 1, Section 5.1. TRICARE reimburses for ABA services provided by TRICARE authorized ABA providers, and therefore the requirements of medical record documentation under the TRICARE Basic program apply. DHA is evaluating whether ABA as a service, and ABA providers as a profession, should be properly characterized as "medical" in nature so as to justify adding it to the TRICARE Basic program. The degree to which ABA providers align their practice to standard health profession standards will have a significant influence on TRICARE's determination concerning the nature of ABA and appropriate status of ABA providers.

Q: How often is the provider number updated? In my experience, the online list is grossly overstated and includes providers that no longer serve TRICARE kids or providers are listed multiple times in different cities/counties.

A: Provider numbers are reported routinely by the TRICARE regional contractors. The online list is not used in the reporting of numbers.

Q: Why is it required to list the referring, treating, or prescribing doctor on the Treatment Plan? Do other treatment plans require the name of the referring doctor?

A: Good practice includes listing all treating providers' names on a treatment plan, which is common practice for multi-disciplinary teams. This allows for the implementation of a comprehensive treatment plan with information readily available for all individuals who handle that document, but most importantly the family.

Q: Would DHA consider a provisional status for BCBAs?

A: DHA will not permit a provisional status for BCBAs as that provider category is being treated like any other independent provider category that is required to be licensed, fully qualified, and authorized under TRICARE to be reimbursed for service, just like any other medical provider for any medical benefit. DHA is evaluating whether ABA as a service, and ABA providers as a profession, should be properly characterized as “medical” in nature so as to justify adding it to the TRICARE Basic program. The degree to which ABA providers align their practice to standard health profession standards (which would exclude provisional status for BCBAs) will have a significant influence on TRICARE’s determination concerning the nature of ABA and appropriate status of ABA providers.

Q: The RAND Corporation study disclosed their numbers were understated by patient cost share amounts. Will the new rate study be including actual amounts billed instead of the amounts paid?

A: According to 10 USC 1079(h)(1), TRICARE follows Medicare reimbursement rules to the extent practicable. Because Medicare does not currently have set reimbursement rates for ABA services, TRICARE is permitted to follow an alternative methodology approved by DHA (TRM, Chapter 5, Section 1, Paragraph 1.0). The methodology selected is based on the available data at the time. The body of evidence has not sufficiently matured to represent accurate billed charges for ABA across the larger health care system and multiple payers to produce actuarially sound data. Once the data is available, TRICARE can reevaluate the methodology implemented. However, once Medicare establishes reimbursement rates, TRICARE will immediately adopt those rates.

Q: Can a BCBA, assistant behavior analyst, or BT substitute for the regularly scheduled BT in the event the scheduled BT is unavailable, i.e., out sick, on vacation, extended leave, etc.?

A: Yes. Other qualified and authorized providers who meet TRICARE ACD standards may substitute for one-to-one sessions. However, documentation to support substitutions must be provided when claims are submitted for reimbursement.

## **Outcomes**

Q: Who is responsible for completing the every two year outcomes evaluations (Autism Diagnostic Observation Schedule, Second Edition (ADOS-2), Vineland Adaptive Behavior Scales, Third Edition (Vineland-3), and IQ testing)?

A: This protocol must be administered and submitted by a doctoral level clinical psychologist, developmental-behavioral pediatrician, neurodevelopmental pediatrician, child and adolescent psychiatrist, or Doctors of Nursing Practice trained in the administration of these measures.

Q: Will you accept IQ testing completed by a school psychologist?

A: IQ testing completed by a PhD school psychologist will be accepted provided the school psychologist is qualified and competent to administer and interpret the particular IQ test. Qualifications include state licensure with a scope of practice that includes IQ testing issued by the state in which the school psychologist is practicing, and competency training to administer and interpret the particular IQ test. IQ testing by a school psychologist must be current (i.e., obtained within the two year period as part of the requirement for the every two year review).

Q: There are BCBA's who are trained in both the ADOS-2 and the Vineland-3. Will they be able to perform these outcome evaluations?

A: No. BCBA's will not be eligible to complete and submit outcomes measures. Only the specialized ASD diagnosing provider category is eligible to complete these outcomes measures. This requirement is aimed at providing objective and external measurements of the progress of ASD symptoms. Additionally, it is not within the scope of practice for BCBA's to interpret these results.

Q: What is the recommendation for completing the 2 year outcomes evaluation? Are parents of beneficiaries required to go through their physician or a psychologist? Is it the BCBA's responsibility to make sure this gets done?

A: The beneficiary is required to complete this requirement for continued services. However, this is a team effort where the TRICARE regional contractors, authorized ABA providers, parents, and DHA work together to ensure compliance for the families. In the rare situation that a family refuses to complete this requirement, they risk termination and discharge from the ACD.

## **Supervision**

Q: Given the three certification boards have already created guidelines regarding supervision of BTs, would DHA consider changing the supervision requirement to link BT supervision to only

BT and not per BT/per individual client, as the skills that must be executed as a BT are transferable by the definition of the registration and competency?

A: DHA will take this request for aligning the supervision requirement of 5% for BTs total direct service for action and make a determination.

Q: The sole reason the credentialing boards exist is to establish and enforce the guidelines for quality therapy. By requiring all BTs to become credentialed, you have ensured that they have all met the common standards for practice, have mastered the skills necessary to deliver services, and will obtain ongoing supervision. Would DHA consider revising the supervision requirement to account for 5% of the total time of direct service for each beneficiary instead of 5% of each BT per beneficiary? By allowing this revision, Tricare could focus on the supervision of the child's program.

A: DHA will take this request for aligning the supervision requirement of 5% to the child's total direct service program for action and make a determination.

Q: If all supervision can be done in a group setting, is remote supervision still an option?

A: Group supervision may be completed remotely as that is still considered direct supervision (authorized ABA supervisor, with BT(s), with beneficiary). However, the manual requires at least one supervision session to be completed in person. The nature of supervision is subject to quality monitoring reviews.

Q: Is group supervision considered a direct or indirect service? If direct service, can this be billed?

A: Group supervision, in this demonstration only, will be considered a direct service as long as the session is defined as:

1. one beneficiary; and
2. one authorized ABA supervisor; and
3. the BT(s) on the one team providing ABA services for that one beneficiary.

The presence of any additional beneficiaries would change the definition to indirect service. Direct group supervision may be billed as 0360T/0361T (Observational Behavioral Follow-Up Assessment – Supervised Fieldwork) for only the authorized ABA supervisor. Billing for additional participants is considered double billing and prohibited by law. Only the authorized ABA supervisor can bill for the supervision session.

[END OF DOCUMENT]