

Questions and Answers

Autism Roundtable #6

April 22, 2016

Access/Wait lists/Referrals

Q: How does TRICARE define wait lists? There is a concern that the information being received from the regional contractors does not reflect what is actually happening in the community.

A: TRICARE defines the term ‘wait list’ as a list of TRICARE beneficiaries who have active authorization for care issued by the regional Managed Care Support Contractor (MCSC) and for whom no TRICARE authorized provider is available. TRICARE does not recognize “wait lists” of individuals who do not have an active authorization or who are not TRICARE beneficiaries. To clarify, if a beneficiary calls to be placed on a ‘list’ without a MCSC authorization for ABA services, that person is not counted as a wait listed individual. TRICARE policy standards for specialty care (including ABA services) require a 28 day access standard. If a provider cannot assess and begin providing treatment to a referred beneficiary within this 28 day access to care standard, please do not put them on a wait list, but rather notify the regional contractor, who will refer the patient to another ABA provider who can see the beneficiary within the 28 day access standard.

Q: Who do we contact if we can't serve a beneficiary for any reason?

A: Your contract is with the regional contractor. Your first contact should be with the MCSC for your region. Contacting the Exceptional Family Member Program (EFMP) office, the Military Treatment Facility, or the referring provider *in addition* is fine, but you must notify the MCSC to ensure the patient receives the recommended ABA services in a timely manner. If you receive an authorization for ABA services and cannot see the beneficiary within the 28 access to care standard, or for any other reason, please immediately notify your regional contractor (United Healthcare, Value Options, or Health Net). You do not need to (and should not) wait until the 28 days has expired if you know you will not be able to see the beneficiary within the 28 day period. Please do not retain any beneficiary for whom you are unable to provide services. The sooner you notify the MCSC, the sooner the patient will receive the care they need. The regional contractors rely on you to help us ensure that TRICARE beneficiaries receive ABA services in a timely manner.

Q: Providers are now being told that network providers who have openings will be sent referrals first, and that providers with wait lists will not receive any more referrals until wait lists are cleared. Please explain how this logic will prevent providers from hiding wait lists?

A: TRICARE policy states that network providers will receive referrals first before referrals are sent to non-network providers. Since we want to ensure our beneficiaries receive timely care, if a provider does not have the ability to provide services within the 28 day access to care standard, we will naturally send referrals to another network provider with availability. If a provider has hours available to accept certain referrals, i.e., during day time hours, it is the provider's responsibility to communicate that information to the regional contractor so the contractor can refer patients who the provider will be able to see. By working closely with the contractor to let them know when the provider has availability within 28 days, providers can help ensure they receive referrals when they have availability, while avoiding having to turn patients away when they cannot see them in a timely manner. This helps improve the system for everyone.

Q: Providers have heard that if they chose to go out of network, their current clients will be removed from their care and placed with the next available network provider. This action fails to take into account the patient's status and wellbeing, benefits of continuity of care, potential for regression with sudden changes, and the importance of established relationships between the patient and the provider. Can you please clarify the conditions for when a patient may be removed from their current service provider?

A: TRICARE policy is that anytime a network provider is available, patients will be referred to network providers. If a network provider is not available, then a non-network provider will be used until a network provider becomes available. However, issues such as continuity of care are taken into consideration. In general, if a TRICARE provider of any type (to include ABA providers) leaves the network, we will work to move that provider's patients to a network provider as soon as possible.

Q: Providers are being told that if they do not accept new clients, they will not receive future referrals. Please explain this rationale?

A: If a provider does not accept or refuses to accept a new referral, then it is presumed that they are not able to accept future referrals. If that assumption is incorrect, then the provider must communicate with the regional contractors their current status/availability. As noted above, close communication with the contractor is crucial.

Q: A recent survey conducted by Behavior Analysis Advocacy Network of TRICARE families found that 66% of respondents are either waiting for services, or they are not receiving the recommended level of care. Please explain DHA's plan to address this short fall in provider availability and steps being taken to ensure patients have access to recommended levels of care.

A: DHA has several concerns about the methodology, validity, and results of this survey. There is no evidence that the survey was reviewed by a statistician; the sample size is not statistically significant, the survey is at risk for bias from several sources; there is no evidence that any attempt was made to control for these biases; this is a convenience sample

obtained through social media; there is no way to validate who the recipients are (to include not knowing if they are TRICARE beneficiaries participating in the Autism Care Demonstration [ACD], of if they have a confirmed diagnosis of Autism Spectrum Disorder [ASD]) with the potential that anyone could have responded to the survey. However, if a beneficiary is waiting for services, DHA has repeatedly instructed both providers and parents to reach out to the regional contractors to assist with identifying an available provider. We have found that in many cases, ABA services were available but the patient did not have an authorization or the MCSC was not aware that they were not receiving the services from the provider to whom the patient was originally referred. Once the MCSC was notified, in most cases they were able to arrange the needed care for the patient.

With regard to receiving the recommended level of care, it is difficult to respond as there may be many reasons why a beneficiary is not receiving the recommended level of care to include but not limited to: family availability (receiving other services, child is in school), resources within a particular practice (short staffed), the beneficiary not being aware that other providers are available who could provide the recommended level of care, parental/beneficiary choice, etc. DHA meets regularly with the regional contractors, EFMP, and TRICARE Regional Offices, to address access concerns as well as other issues related to the ACD to ensure our beneficiaries are receiving the best care possible.

Q: What is being done to address the increasing access to care issues for military families in North Carolina/Camp Lejeune area? Orders have been halted off and on by EFMP Head Quarters over the past 3-5 years because of ABA access issues.

A: We are currently looking into the North Carolina/Camp Lejeune area regarding concerns of limited access to ABA services. The referral and authorization process continues to be a team effort between the providers, the contractors, and the families. It is important to keep in mind that providers should not keep beneficiaries with active authorizations on a wait list if they cannot provide services with the 28 day access to care standard. As stated in the authorization letter to both the beneficiary and the provider, if an appointment cannot be made in the 28 day access to care standard, the provider *and* the family should contact the regional contractor to notify them that another provider will need to be identified. Simply telling the family to call around to other providers is not sufficient. Our contractors are responsible for finding providers for our patients, but they cannot do so if they do not know the patient is not receiving care.

Authorizations

Q: The reauthorization process (every six months) is time-consuming and requires a lot of communication between the parents, pediatricians, and ABA supervisors. Would TRICARE consider returning this authorization period to the annual time frame?

A: The six month TRICARE authorization period is in line with the prior authorization requirements for outpatient mental health services under Medicare. TRICARE follows Medicare whenever practicable. Medicare authorizes 20 visits per authorization for outpatient mental health services (i.e. outpatient psychotherapy, which based on one visit per week for 20 weeks, or approximately five months per authorization, see Beacon Health Strategies, 2009; IN.gov, 2011; and Medicare.gov). Additionally, TRICARE authorizations under the previous Extended Care Health Option (ECHO) Autism Demonstration for Active Duty Family Members (from 2008-2014) were for six months. At the beginning of the ACD, the annual authorization was set to allow for all authorizations to easily transition to the new program. Once the transition to the ACD was complete, authorizations returned to every six months to align with the requirement for ABA providers to submit the ABA reassessment and treatment plan updates to the MCSCs. The MCSCs had reported not receiving the every six month reassessments and treatment plan updates in a timely manner when the authorization period was for one year. This problem was resolved after the Department returned the authorization to every six months. TRICARE's goal of shaping this benefit to mirror a medical benefit includes aligning authorization requirements to that of other TRICARE healthcare benefits.

Q: Regarding direct one-to-one ABA services, does TRICARE have any plans to streamline Tiered and Sole Board Certified Behavior Analyst (BCBA) authorizations? For example, if a BT is unable to fulfill the schedule (i.e., sick, on vacation), another provider, perhaps the supervising BCBA, will fill in appointment time. The regions do not appear to have the same process for allowing this flexibility. Please address.

A: This question has been taken for action and will be addressed in the near future.

BLS/CPR

Q: Is the Basic Life Support (BLS) certification required for all people who currently have a valid Cardiopulmonary Resuscitation (CPR)/First Aid certificate obtained prior to 2016?

A: All authorized ABA supervisors, assistant behavior analysts, and behavior technicians, are required to obtain in-person BLS or CPR equivalent certification (e.g. CPR for Healthcare Providers offered by American Red Cross and other equivalents). All current certifications are honored until their expiration date. At that time, recertification must comply with the TOM Ch 18, S 18, P 6.1.11, P 6.2.6, and P 6.3.3.1. In other words, the first time recertification is due, after January 1, 2016, everyone must be compliant with the TOM. We are tracking compliance and we expect ALL ABA providers to be in compliance with this requirement by September 30, 2016.

BT Certification

Q: Please confirm that BTs hired in 2015 have until 12/31/2016 to obtain their Registered Behavior Technician (RBT), Applied Behavior Analysis Technician (ABAT), or Board Certified Autism Therapist (BCAT).

A: Yes, BTs hired in calendar year 2015 have until December 31, 2016 to obtain their certification from one of the three approved credentialing bodies. Also, a reminder that all legacy BTs, meaning those hired prior to January 1, 2015, also have until December 31, 2016 to obtain their certification. It is recommended that you do not wait until the end of the year (2016) to obtain this certification.

Q: Could you review the most efficient and quickest way to credential our BTs through TRICARE? Please provide information on the current time lines for each region, what is being done to reduce delays, and what level of oversight and tracking DHA is providing to see that this process becomes more efficient and responsive.

A: Once a BT obtains certification through one of the three certifying bodies, they should submit a complete application packet to the MCSC. Submission of a complete packet is critical to the timeline. Delays in processing typically are a result of an incomplete packet. While the healthcare industry standard for processing a credentialing packet is 90 to 120 days, applications under the ACD for BTs are averaging between 15 and 45 days for the three regions; this timeline for ABA providers is shorter than the timeline for any other type of provider the contractors credential. While DHA is regularly engaged with the contractors to ensure the credentialing process is as brief as possible, please understand that thorough verification of the information in a credentialing package is very important to ensure our patients receive safe, quality care, and this verification does take some time. Please check with your MCSC on the status of your application to ensure that your packet is complete.

Q: Why are the contractors delaying application processing until an RBT certification number is on the Behavior Analyst Certification Board (BACB) website? Per the TOM, only a copy of the certification is required.

A: As part of the credentialing process, primary source verification of the BT certification by the MCSC is required (TOM, Ch. 4, S. 1, Paragraph 2.2; TRICARE Policy Manual Ch. 11, S. 12.1, Paragraph 2.4). Submitting a copy of the certification is only one part of application. This requirement is the same for all credentialing packets for all TRICARE providers.

Q: Is there any plan to implement a window to get new BTs credentialed - for example 90 days - and allow them to work on TRICARE cases during that time? It is becoming a hardship for families to get services because of a lack of available certified BTs. Would it be possible to create a grace period for BTs? What is the expected timeline for notification with a decision about grace periods?

A: DHA has received several proposals regarding BTs rendering services to TRICARE beneficiaries prior to receiving credentialing status from the MCSCs. This question has been taken for action and will be addressed in the near future.

Q: TRICARE requires additional education requirements above and beyond what is required to obtain a BT certificate (TOM Ch 18, S 18, P 6.3.2). Do you see this TRICARE requirement being removed in the future as the BT certificate only requires a high school diploma or GED/national equivalent?

A: It is important to remember that these educational requirements were historically put in place when there were no certification requirements. Once all current BTs, to include those hired in 2015 and before, have obtained certification from one of the three certifying bodies, TRICARE will review the current requirement and determine a way forward.

Q: What is the justification for accepting the non-accredited credentials issued by the Qualified Applied Behavior Analysis Board as evidence of qualification to practice ABA?

A: The main purpose of the ACD is to pilot how this benefit would be delivered consistent with the delivery of other mental health and medical benefits under TRICARE. According to the section of the Code of Federal Regulations (CFR) which governs TRICARE authorization of individual providers, 32 CFR 199.6(c)(3), if BTs were consider to be individual providers, authorization to provide care would rely in part on state licensure or state certification where that exists. In many states, however, BT licensure or state certification do not exist, therefore, where there is no licensure of a specific category for an individual professional, the certification by a qualified accreditation organization is required. TRICARE regulation defines what a qualified accreditation organization is in 32 CFR 199.2. It is important to note as well that TRICARE regulation also authorizes the Assistant Secretary of Defense for Health Affairs to determine what credentials are appropriate.

Currently, the Behavioral Intervention Certification Counsel (BICC) is the only certification body that has an accredited BT credential. The BCAT credential is accredited by the National Commission for Certifying Agencies. Both the RBT by the BACB and the ABAT by QABA are in the process of obtaining accreditation, which meets the requirements of the ACD. Currently, DHA recognizes all three credentials as meeting the essential elements for BT certification

Reimbursement Rates

Q: Please clarify when the new rates begin, April 1 or May 1?

A: As of April 1, 2016, the revised rates in the 89 existing Medicare localities will take effect. On May 1, 2016, the revised rates for the 14 new California localities will take effect.

Q: What is TRICARE's response to ignoring providers, beneficiaries, and now even senators concerns about how the rate cuts will adversely affect access to ABA services?

A: TRICARE has not ignored those concerns. We regularly meet with our MCSCs, EFMP coordinators, pediatric providers, and others including attendees of the round tables and meetings with the Senators and Members of the House of Representatives. We continue to be in direct contact with providers and the parents of our beneficiaries. We take all of the input and concerns very seriously. At this point, we continue to maintain a strong network of providers, and in fact we have had a net increase in overall ABA providers since the rate revisions were first announced in December, 2015. There are a few geographic areas that we are monitoring for shortages, but our MCSCs are actively working to recruit new providers. Be assured that we have not ignored those concerns.

Q: Why, after 8 years of no fee increases, would TRICARE reduce the rates for providers in high-cost metropolitan areas?

A: The current rates were never intended to set the standard for a medical benefit. They were established in 2008 under a previous demonstration program to enhance access to services for the Active Duty families as an educational benefit, not a medical benefit. Continuing the rates at their previous levels nationwide would not be supportable by law. Adjusting and aligning the rates takes into account the 89 Medicare locality factors and will now include the 14 additional localities in California, which are established by Centers for Medicare and Medicaid Services (CMS). This process accounts for the prevailing rates in both urban and rural markets, and brings reimbursement for ABA services much closer to the way all TRICARE medical benefits are reimbursed. Reimbursement rates for other Current Procedural Terminology (CPT) codes, both medical and behavioral health, have seen rate changes, both increase and decrease, over time depending on the market.

Q: Are you at all concerned that changes in reimbursement rates will cause providers to leave the network, thereby adversely affecting access to care?

A: Access is monitored regularly and will continue to be monitored. And, yes we are always concerned about the potential impacts on access as well as making sure we have an adequate network of high quality providers. We are tracking the size of the network very carefully for each region. At this point, we have not seen evidence that the rate changes are adversely impacting access to care.

Q: Other funding sources are paying us over 30% more than the TRICARE rates and don't have the same policy requirements. Why should we continue taking TRICARE beneficiaries, especially knowing more cuts are coming?

A: The TRICARE and Medicare rates are never the highest, nor are they the lowest, but they are very competitive. The TRICARE rates are even more competitive when considering the

TRICARE Prime benefit for Active Duty families is without question the best in the nation because providers never have to balance billing patients or budgeting for collections on unpaid bills due to TRICARE paying 100% of the allowed fee. Our Active Duty families, unlike most families, do not have to make financial decisions regarding the affordability of authorized care. The same can be said for our military retirees on TRICARE Prime as they have minimal out-of-pocket costs and are protected by a catastrophic cap.

Q: At the last round table it was stated that the maximum reduction in reimbursement rate would be no more than 15%. However, the new rates specifically, one-to-one implementation represent almost a 30% decrease. Why was this statement not followed as stated at the previous round table discussion?

A: The current reimbursement rate sheet was posted March 23, 2016. No rates decreased by more than 15%. This rate spread sheet can be found at www.health.mil/autism

Q: Why does TRICARE requires all one-to-one direct therapy be billed under each individual BT rather than under the BCBA?

A: Claims process under TRICARE requires that a rendering and billing provider be identified as a way to distinguish who is providing the service and to reimburse at the appropriate rate. If there are any further questions about how to efficiently submit claims, please contact your MCSC or PGBA (the current claims processing subcontractor for all three TRICARE regions) representative.

Q: It is extremely unlikely that there will be standard Medicare reimbursement rates in place for ABA services by the fall, or even by the end of this year. So what will TRICARE use as the basis for adjusting rates?

A: If Medicare does not establish rates in the next year, we will follow the exact same process as we did this year. We will resurvey all 50 states, obtain their statewide Medicaid rate, recalculate the national rate, and verify the locality factors each year going forward until Medicare rates are established.

Q: I understand using Medicaid as a baseline, however Medicaid allows us to bill for outside work and the new rates do not accommodate this. How are these new rates really representative of the Medicaid rates?

A: TRICARE is required to follow the established laws set forth by Title 10, U.S.C. 1079, which include limiting the use of certain CPT codes. Other commercial carriers are not required to follow the same laws as what they can and cannot cover. There are a variety of Medicaid programs, to include those programs under the Home and Community based waiver programs (37 states currently place their ABA programs here), which may allow you to separately bill for other administrative non-healthcare related services that are not

allowable under TRICARE. Therefore, factoring in those services would be inappropriate as TRICARE is prohibited from billing for administrative service. Furthermore, each current Category III ABA CPT code already factors in administrative duties as an embedded pre and post service.

Q: It was mentioned that it is required by law that TRICARE follow Medicare's rates. Could you please indicate where that law is written, and to whom one would petition for an amendment to that law?

A: TRICARE program reimbursement of authorized individual health care professionals (or other non-institutional health care providers) must, to the extent practicable, be the same as Medicare. The reference in the Federal Code is 10 U.S.C § 1079(h)(1), this also applies to any "provider of services" (i.e., institutional providers) [10 U.S.C § 1079(j)(2)]. Changes to Title 10, U.S. Code must be enacted through the legislative process (i.e., passed by Congress and signed by the President).

Q: Will DHA consider revising the rate determination procedures?

A: No. By law, TRICARE program reimbursement of authorized individual health care professionals (or other non-institutional health care providers) must, to the extent practicable, be the same as Medicare. The methodology implemented for determining the current ABA reimbursement rates under the ACD best predicts what the Medicare rates would be if present today. Rates will be calculated annually in conjunction with all other TRICARE reimbursement rates. When Medicare establishes rates, those rates will be adopted by law.

Q: We had previously entered into an agreement of a reduced rate; however, we can no longer afford this rate reduction. I am assuming the rate change will nullify previously negotiated rate reductions?

A: You will need to contact your MCSC to address your individual contract. The name and number to contact should be on the documentation you received when you signed the contract originally.

Q: It was indicated in the round table that we could negotiate with the contractor's is that to say that ABA providers can negotiate with TRICARE for reimbursement rates?

A: TRICARE does not negotiate the set rate. However, the contractors are permitted to negotiate rate reductions in return for network status. The reference to rate negotiations at the round table was in regards to the rate reduction agreement for network status. This negotiation must be addressed with your respective regional contractor with whom you signed (or are considering signing) a network contract.

Q: Why did the rates in the DC area get cut from the proposed \$60 to \$48 for 0364/0365T? What new information was incorporated?

A: There was an error in the assistant behavior analyst and BT rate that was sent to TRICARE by the District of Columbia Medicaid office in the original December rate posting. In the resurvey, completed in January and February, the correct information was obtained, and the TRICARE rates were revised based on the corrected information.

Q: Why is TRICARE proposing to reimburse providers at rates that are lower than what Medi-Cal offers in some areas of California? Can TRICARE revisit the California rate offerings?

A: TRICARE has set ABA rates in 23 different localities in California and in no cases do these rates fall below the state-wide fee-for-service rates set by California's Medicaid program (Medi-Cal). TRICARE's method of setting local maximum rates for an array of eight different types of ABA services involves a multi-step process: (1) calculate TRICARE National Rates based on statewide Medicaid rates (weighted by the number of children diagnosed with ASD who rely on public insurance), (2) adjust National Rates upward by 28% to approximate the level of reimbursement that Medicare would have set if it covered these services, (3) calculate TRICARE rates for each of the 107 TRICARE localities based upon Medicare's geographic adjustment factors, and (4) ensure that the rates are not less than 85% of the 2015 TRICARE level in any given locality. An exception to this approach is made in cases where Medicaid has set statewide ABA rates that exceed these locally determined rates for the same array of services. In these cases, the statewide Medicaid rate is substituted as the local rate. The exception does not take into account non-statewide rates paid by Medicaid managed care organizations for ABA services within a state. This is for several reasons, including that these are region-specific and not statewide Medicaid rates, DHA does not have access to these plan-specific, negotiated, and proprietary rates.

Statewide ABA rates established by California's Medicaid program (Medi-Cal) for its fee-for-service population were below all local rates determined by the above process.

It is important to note that Medi-Cal covers ABA services under both a state-wide fee-for-service system and a managed care system with multiple plans. As is the case in other states, Medi-Cal allows their managed care plans the flexibility to set their own rates for these services when provided to their enrolled beneficiaries. Medi-Cal managed care contracts for health care services through established networks of organized systems of care, tend to be region-based (e.g., Alameda Alliance for Health in Alameda county). Although we do not know Medi-Cal managed care rates for ABA services, it is possible that, in some areas, their rates are higher than TRICARE's local maximum rates. However, as indicated above, DHA does not take into account non-statewide rates paid by Medi-Cal managed care plans for ABA services within California.

Diagnosis

Q: What is the rationale for requiring diagnosing providers to specify a beneficiary's level of symptom severity?

A: In the ACD policy, we require that the specialized ASD diagnosing provider include symptom severity in the diagnosis when they do their evaluation. This is in accordance with the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5) diagnostic criteria. There is a symptom severity matrix in the DSM 5, page 52, which delineates severity according to level of support needed. The level of support is an important piece of information in knowing the needs and level of support services that a beneficiary may require.

Q: How often is a new Evaluation/Diagnosis required? Is the initial diagnosing provider required to complete any additional diagnoses in order for treatment to continue?

A: A diagnostic evaluation for the diagnosis of ASD is required only at the outset of treatment. The referring/diagnosing provider should be reviewing the treatment progress at least every six months (with the submission of the ABA reassessment and treatment plan update) to evaluate the symptom presentation and subsequently ABA is authorized in six month intervals. Once the initial ASD diagnosis is made, we do not ask for another diagnosis unless it was made by a primary care physician, in which case, the beneficiary has one year to have the diagnosis confirmed by a specialized ASD diagnosing provider either through ADOS-2 testing or a diagnostic evaluation.

Q: If the beneficiary's initial diagnosis was made by a specialized ASD diagnosing provider, is there a specific time limit prior to the beneficiary's starting of ABA services in which this diagnostic evaluation had to have been conducted? If so, what exactly is the time limit and where in the ACD policy does this limit appear?

A: The ACD policy does not currently identify a designated time period prior to beginning services where the initial diagnosis must be rendered. Hopefully beneficiaries new to the ACD begin ABA services soon after they are diagnosed. We do not want delays in access to ABA services. That said, thank you for bringing this issue to our attention as this is a critical question and will be included in the next manual revision. Regular evaluations should be conducted to assess current levels of impairment. If ABA services were not rendered shortly after diagnosis, a follow up diagnostic evaluation may be required to assess the current treatment need based on level of impairment. Please follow the MCSC best practice guidelines for clinical implications.

Treatment plan

Q: If parents are not interested or able to complete the goals, how is this documented? Will a beneficiary lose services if parents/caregivers are not participating or meeting their goals?

A: While a statement in the treatment plan documenting why there is a lack of parent participation is sufficient, every effort should be made to engage the parents in some capacity. Parental involvement is viewed as essential to any ABA treatment plan; this is

supported by the BACB guidelines as well as ABA research literature. It is expected that the authorized ABA supervisor would continue to engage the parents in treatment as parents are the key to generalization of mastered skills. Generally, it is not possible to provide the best quality of care if the parents or caregivers are not involved. We do recognize there are some circumstances where a parent cannot participate, for example if they are deployed. Lack of parental/caregiver participation solely will not result in a denial of services, however, if lack of parental/caregiver involvement proves detrimental to the treatment goals, this must be addressed.

Q: Can we please get clarification regarding how DHA is defining parent participation?

A: Parental participation should include implementation of the treatment goals. An effective treatment plan should not solely rely in the ABA team as generalization of skills is expected. Parents should be knowledgeable in and practice these techniques in order to enhance generalization. However, the ability of parental involvement must be determined by their capacity to participate. Refusal to participate should be addressed as part of the treatment plan.

Q: Is it true that beneficiaries will lose services if they aren't meeting the goals of their treatment plans?

A: The goal is to assist the beneficiaries to improve and to make progress on the treatment targets, and it is the view that ABA services should result in some progress. This is where documentation is critical. TRICARE relies on the documentation submitted in the ABA reassessment and treatment plan update to provide the whole picture, to include extenuating circumstances that may have triggered a regression or a lack of progress. While a lack of progress does not necessarily mean termination of services, a lack of progress may result in transitioning to another provider or type of service that may more effectively help the child. The number one goal is to make sure these children receive the care they need in order to maximize outcomes and help each person reach their full potential.

Q: Is it appropriate that these decisions are being made by individuals from contractors who have never met the child and don't know the entire situation?

A: Yes, it is appropriate for the contractors to make decisions about coverage. The MCSCs receive the successive reassessments and treatment plan updates which result in the Periodic ABA Program Review. At this time, they look at the overall progress for each individual beneficiary. This is the same process for other TRICARE benefits. It is the responsibility of the MCSC to assess whether a particular treatment is appropriate and/or effective. Ultimately, this is a clinical decision and the MCSCs work with the authorized ABA supervisors and the parent/caregiver to provide the best treatment to meet the needs of the child in order to reach the optimal level of functioning.

Q: How do we address with the MCSCs a subjective opinion on how a goal is to be written?

A: The MCSCs follow their best practice policies. The best approach to this issue is to work with the ACD-specific personnel at the contractor. It is the responsibility of the treating provider to present clinical justification for various treatment goals that appear “subjective.” If there is an impasse, it is recommended that you seek consultation from another provider to incorporate the feedback and appropriateness of the goal. In some cases, use of the TRICARE appeals process (available from the contractor) may be appropriate as well.

Q: How would DHA recommend ABA providers respond to requirements from the Regional Contractors that go outside of the TOM requirements and in some instances directly contradict the TOM and the FAQs put out by DHA?

A: The MCSCs implement their best practices when implementing any TRICARE program. DHA relies on the MCSC to determine what additional requirements are necessary to successfully implement the benefit. Please contact your regional contractor for additional information regarding their best practices.

Outcomes

Q: What metrics will TRICARE use for the evaluation of the ACD that is to be completed by the end of 2018?

A: An announcement of the metrics to be used for the ACD will be announced in the next few months. We invite input from providers and others regarding effective ways to measure outcomes in children diagnosed with ASD.

Q: Changes in requirements to becoming certified and reimbursement rates in the middle of the demonstration program will clearly skew the results of the demonstration, especially as it relates to evaluating access and utilization and the value of these TRICARE services. How will you address this issue and ensure that the data will accurately reflect outcomes before and after the changes in policy mid-way through?

A: One of the goals of the ACD is to shape this benefit to mirror other TRICARE medical benefits should it eventually become part of the basic medical benefit. Aligning certification/licensure standards and reimbursement rates are part of that process and were announced in the Federal Register notice at the outset of this demonstration. BT certification was also announced at the outset of the ACD and was initially required by December 31, 2014, but was extended twice. The change in reimbursement rates was initially set for implementation for October 1, 2014, but was placed into abeyance pending the findings from the RAND Corporation and other independent studies. Thus the certification requirements and rate changes are an important part of the demonstration.

Q: Is TRICARE still considering dropping all coverage for ABA services if some unspecified new research is not obtained by the end of ACD period?

A: TRICARE is not going to drop treatment for our children diagnosed with ASD. The number one goal is to make sure these children receive the care they need in order to maximize outcomes and help each person reach their full potential. However, TRICARE must make decisions before the end of the demonstration to include obtaining clinical evidence about the most effective methods of treatment so that we can ensure our beneficiaries have the best outcomes possible. At this time, research has not been able to determine optimal treatment characteristics such as what is the right dose, intensity, and frequency for specific domains for a person diagnosed with ASD, and which individuals diagnosed with ASD are likely to benefit from ABA techniques. The ACD must include outcome measures to address our specific population and to help tailor the right treatment to the right patient at the right time. With sufficient evidence, ABA services could become part of the medical benefit at some point in future.

TQMC Audit

Q: What is the purpose of the upcoming ACD assessment/reassessment and treatment plan/treatment plan update audit? What is the audit measuring? Will results of the audit be used to deny claims and recoup payments for treatment plans that may not be “perfect” or will the results be used to improve processes for the ACD?

A: The purpose of this ACD audit is to assess compliance with the requirements of the ACD. Previously submitted assessments and treatment plans will be used for this audit. No additional documentation submission is required. Results of the audit will be used to inform ACD manual compliance and future manual revisions with the goal of improving the quality of care to our beneficiaries. As with any chart audit, there may be payment recoupment.

Payment of claims

Q: Prior to April 1, remittances and payments were being processed very quickly, most within a two week period of time. Since April 1, no remittances/payments have processed at all. How long will this delay continue?

A: With the new reimbursement rate implementation, the payment system needed to verify that all zip codes mapped to the correct rates. This issue has been resolved. Please check with your MCSC or PGBA (the payer for the three regions) representative if you have further questions.

CPT Codes

Q: Given the widely recognized problems with the Category III CPT codes for “adaptive behavior” services and the fact that those codes are temporary, would TRICARE consider going

back to using H codes (e.g., H2019, H2020) or supplementing the Category III codes with H codes and/or other CPT codes to better capture the essential components of ABA services?

A: No, we will not go back to non-standard usage codes. When there are official American Medical Association (AMA) CPT codes, even category III codes, TRICARE uses the official codes. Even though these are category III codes, which refer to temporary codes for new and promising or emerging treatment, we will be using them. We are carefully monitoring the developments by the AMA CPT ABA code committee and we will implement category I codes if and when they are developed and approved.

Q: Is TRICARE aware that there are more CPT codes for ABA, such as social skills groups, group parent training, etc.? Are there plans to cover those codes?

A: TRICARE is aware that AMA has published other ABA CPT codes. However, TRICARE is prohibited by statute from covering codes such as social skill and group training. Therefore, these are not permissible under the ACD. There is no plan to include coverage for these codes into this demonstration.

Q: Since TRICARE modified some of the CPT codes, please provide guidance on how each code should be used.

A: The ACD did in fact modify the CPT code 0360T/0361T (Observational Behavioral Follow-Up Assessment – Supervised Fieldwork) to allow for reimbursement of supervision for one authorized ABA supervisor, or delegated to the assistant behavior analyst, and one BT with one beneficiary (direct supervision). There is no AMA Category III CPT code for supervision because CMS does not recognize supervision as an independent reimbursable service. According to the AMA CPT guidance, there are no separate codes for supervision because supervision is considered a component service, not a separate service from the service delivered by each CPT code. Supervision is considered an administrative task under TRICARE, and is therefore excluded from coverage, in accordance with the AMA CPT rules. TRICARE made an exception under the ACD Demonstration authority, which affords more flexibility than Basic Program requirements.

CPT code 0359T (ABA Assessment and ABA Treatment Plan [TP]) should be used at the outset of ABA for the initial ABA assessment and ABA TP development, as well as at the reauthorization period for the ABA reassessments and TP updates.

CPT code 0364T/0365T (Adaptive Behavior Treatment by Protocol) should be used only for the direct one-on-one ABA interventions delivered by the authorized ABA supervisor, assistant behavior analyst, or BT, to the beneficiary.

CPT code 0368T/0369T (Adaptive Behavior Treatment by Protocol Modification) should be used for all treatment plan modification/updates between the six month reassessment and

treatment plan update. These codes are also used to demonstrate a new or modified protocol to a BT and/or parents/caregivers (AKA “treatment team meetings”).

CPT code 0370T (Family Adaptive Behavior Treatment Guidance) should be used only for the guidance to the parents/caregivers to implement the ABA TP protocol.

For additional information and further questions, please reference TOM Ch 18, S 18 and contact your regional contractors.

Mental Health Parity

Q: Isn't requiring the Individualized Education Program (IEP) in order to have services and the parent training component a violation of the Mental Health Parity and Addiction Equity Act (MHPAEA)?

A: No. Neither the IEP nor the parent guidance component is in violation of MHPAEA. Generally, the MHPAEA does not apply to the Military Health System. However, DHA has our own policy to align TRICARE with the goals of MHPAEA. Incorporation of the IEP is no different than any other pre-authorization requirement to obtain a specific benefit. Other benefits may also request supportive or supplemental information such as collateral information for bariatric surgery. The IEP is also incorporated to avoid duplicative or contraindicated services. For parental guidance, entities independent of TRICARE, such as the BACB and the AMA CPT codes, have identified/endorsed parental involvement as critical elements of any treatment plan. Additionally, there are many medical services that require training for the parent or caregiver such as lift devices or range of motion therapy for contractures and spasticity.

Regional Contact information

Q: Access to points of contact at the contractor level that can answer policy, authorization, payment, and credentialing questions is another area of concern that still exists. While providers and beneficiaries have access to 1-877-MYTRICARE, the information provided from customer service personnel is often incorrect placing the reliability on information received in doubt. In previous roundtable meetings, it was discussed that providers and beneficiaries would be provided with points of contact to resolve ongoing issues and barriers to services. Can you provide an update on this?

A: Please use the following phone numbers for all ABA-related questions. All three Regional TRICARE Contractors have ABA-trained representatives and access to subject matter experts for consultation.

- Humana/ValueOptions (South Region): 1-866-323-7155, ABA Customer Service

- HealthNet (North Region): 1-877-874-2273, Customer Services (ask to speak with their Autism specialists)
- UnitedHealthcare (West Region) 1-855-874-6800: ECHO/Autism Line