Chapter 18 Section 4

Department Of Defense (DoD) Comprehensive Autism Care Demonstration (ACD)

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1.0 PURPOSE

The Comprehensive Autism Care Demonstration ("Autism Care Demonstration") provides TRICARE reimbursement for Applied Behavior Analysis (ABA) services to TRICARE eligible beneficiaries diagnosed with Autism Spectrum Disorder (ASD). Beneficiary eligibility is outlined in paragraph 4.0. The purpose of the Autism Care Demonstration (ACD) is to further analyze and evaluate the appropriateness of the ABA tiered-delivery model under TRICARE in light of current and anticipated certification board guidelines. Currently, there are no established uniform ABA coverage standards in the United States (US). The ACD seeks to establish appropriate provider qualifications for the proper diagnosis of ASD and for the provision of ABA services, assess the feasibility and advisability of establishing a beneficiary cost-share for ABA services for ASD, and develop more efficient and appropriate means of increasing access and delivery of ABA services under TRICARE while creating a viable economic model and maintaining administrative simplicity. The overarching goal of this demonstration is to analyze, evaluate, and compare the quality, efficiency, convenience, and cost effectiveness of ABA services that do not constitute proven medical care provided under the medical benefit coverage requirements that govern the TRICARE Program.

2.0 BACKGROUND

Since 2001, ABA services (paragraph 11.3) have been a benefit for Active Duty Family Members (ADFMs) in the Program for Persons with Disabilities (PFPWD). In 2005, the PFPWD program evolved to become the Extended Care Health Option (ECHO) Program for ADFMs only. This benefit for ADFMs was expanded to cover the tiered model (assistants and behavior technicians) in March, 2008 when the Enhanced Access to Autism Services Demonstration began. In 2012, TRICARE was court ordered to provide ABA services to all eligible non-ADFMs. To comply with the court order, the ABA sole provider model was separated and offered under the TRICARE Basic program despite ABA services not yet meeting the reliable evidence standards as "proven, medically effective" care. In 2013, the court order was overturned. The National Defense Authorization Act (NDAA) of Fiscal Year (FY) 2013 required a one-year Tiered Model ABA pilot for non-ADFMs. The current TRICARE ABA services benefit has been authorized under the TRICARE demonstration authority through the ACD since 2014. The ACD consolidated all previous ABA policies into a single program for all TRICARE eligible beneficiaries diagnosed with ASD. A **Federal Register** Notice to extend the ACD beyond the original expiration date of December 31, 2018, for an additional five years, was published on December 11, 2017. The ACD is currently authorized through December 31, 2023.

3.0 DEMONSTRATION GOALS

3.1 Analyzing and evaluating the appropriateness of the ACD under TRICARE in light of current and future Behavior Analyst Certification Board (BACB) Guidelines for "Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers" (2014 or current edition);

3.2 Determining the appropriate provider qualifications for the proper diagnosis of ASD and for the provision of ABA, and assessing the added value of assistant behavior analysts and Behavior Technicians (BTs) beyond ABA provided by Board Certified Behavior Analysts (BCBAs);

3.3 Assessing, across the TRICARE regions and overseas locations, the ASD beneficiary characteristics associated with full utilization of the ACD's tiered delivery model versus utilization of sole provider BCBA services only, or non-utilization of any ABA services, and isolating factors contributing to significant variations across TRICARE regions and overseas locations in delivery of ABA;

3.4 Determining what beneficiary age groups utilize and benefit most from ABA interventions;

3.5 Assessing the relationships between receipt of ABA services and utilization of established medical interventions for children with ASD, such as Speech-Language Pathology (SLP) services, Occupational Therapy (OT), Physical Therapy (PT), and pharmacotherapy; and

3.6 Assessing the feasibility and advisability of establishing a beneficiary cost-share for ABA services as a treatment for ASD.

4.0 BENEFICIARY ELIGIBILITY FOR THE ACD

4.1 To be eligible for the ACD, a participant must be a TRICARE eligible beneficiary enrolled in an eligible TRICARE Plan Option.

4.2 TRICARE eligible beneficiaries must receive a definitive diagnosis of ASD. See paragraph 4.2.1 for diagnosis requirements. Diagnosis and referral for the ACD occurs under the TRICARE Basic program.

4.2.1 Diagnosis

4.2.1.1 The contractor shall collect proof of a definitive diagnosis, including initial date of diagnosis, through either a referral reflecting a diagnosis of ASD or a diagnostic evaluation. TRICARE eligible beneficiaries must receive a definitive diagnosis of ASD using the Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSM-5 (or current edition)) criteria by an approved ASD diagnosing provider (Primary Care Manager (PCM)) or specialized ASD diagnosing provider (see paragraph 11.13). A diagnosis based on clinical interview alone is not sufficient documentation to support clinical necessity of services described within this section. The DSM criteria must be documented in a DHA-approved checklist in the referral.

4.2.1.2 A validated assessment tool (from the following list, the most current edition of the following: Screening Tool for Autism in Toddlers and Young Children (STAT), Autism Diagnostic Observation Schedule-Second Edition (ADOS-2), Autism Diagnostic Interview-Revised (ADI- R), Childhood Autism Rating Scale-Second Edition (CARS-2), Gilliam Autism Rating Scale, Third Edition

(GARS-3)) must be administered by a TRICARE authorized diagnosing provider, and results must be submitted to the contractor.

Note: A parent questionnaire alone is not sufficient for diagnostic documentation.

4.2.1.3 The contractor may accept the diagnosis, on a case by case basis, if the diagnosis was made by a provider who is not TRICARE authorized, but would be otherwise eligible as an authorized TRICARE ASD diagnosing provider (paragraph 11.3), and the diagnosis meets the requirements set forth in paragraph 4.2.1.

4.2.1.4 Beneficiaries participating in the ACD prior to publication of this manual are not required to obtain updated documentation until their next two year referral appointment which includes paragraphs 4.2.1.1 and 4.2.1.2. If paragraphs 4.2.1.1 and 4.2.1.2 already exist in the beneficiary's file, then they will have met the requirement and no new information is needed. Beneficiaries reaching their two year referral on or after October 1, 2021 are deferred until their next two year review date.

4.3 Dependents of Active Duty Service Members (ADSMs) must be registered in the ECHO program per TRICARE Policy Manual (TPM), Chapter 9, Section 3.1. That manual section outlines ECHO registration requirements to include provisional status and, in certain circumstances, waiver of the Exceptional Family Member Program (EFMP) requirement.

4.3.1 The contractor shall begin the permanent status when the beneficiary's Defense Enrollment Eligibility Reporting System (DEERS) record is updated with the Health Care Delivery Plan (HCDP) code 400.

Note: No extensions will be authorized after the provisional period.

4.3.2 The contractor's Autism Services Navigator (ASN), when assigned (see paragraphs 6.1 and 11.11) shall notify the parent or guardian (or the beneficiary, if an adult) in writing of the provisional status start date and the steps to register in ECHO.

Note: The DEERS Eligibility Response will return the HCDP code 400, which indicates the beneficiary is registered and eligible to receive ECHO benefits. ASN and ABA services will be discontinued at the end of the 90th calendar day if ECHO registration is not completed. The ECHO program as currently outlined in 32 CFR 199.5 remains unaffected by the ACD. The cost-share liability provisions in TPM, Chapter 9, Section 16.1 are applicable only to ECHO services, not the ACD. All ABA services are provided under the ACD. The cost-share liability for ABA services under the ACD are outlined in paragraph 8.11.8.

4.4 The contractor shall, for new beneficiaries entering the program on or after October 1, 2021, assign a non-clinical outreach coordinator for up to 180 calendar days to beneficiaries interested in participating in the ACD, but who require assistance in meeting the eligibility requirements set forth in paragraph 4.0.

4.5 Eligibility for benefits under the ACD ceases as of 12:01 a.m. of the day after the end of the ACD, or when the beneficiary is no longer eligible for TRICARE benefits.

4.6 Ineligibility for the ACD does not preclude TRICARE eligible beneficiaries from receiving otherwise allowable services under TRICARE.

5.0 SERVICES AVAILABLE TO BENEFICIARIES DIAGNOSED WITH ASD

Many services for the management/treatment of ASD are covered under the Basic benefit, while others are covered under the ACD, as noted below. In addition to the services listed here, other services may be available from other sources within the DoD (i.e., Military OneSource, Service-funded Respite, etc.), other government programs such as the Medicaid Waiver program, and other non-clinical services such as an Individualized Education Program (IEP) or Individual Family Service Plan (IFSP). It is important to note that not all services may be clinically appropriate for all people, families, or situations.

5.1 Services for the diagnosis of ASD covered under the Basic benefit and follow respective referral and authorization processes include, but are not limited to:

- Medical team conference with interdisciplinary team of health care professional (see paragraph 8.6.5).
- OT (TPM, Chapter 7, Section 18.3).
- Pharmacotherapies (TPM, Chapter 7, Section 3.13).
- PT (TPM, Chapter 7, Section 18.2).
- Psychotherapies (TPM, Chapter 7, Section 3.8), to include Parent-Mediated Programs (see paragraph 7.1.5).
- Psychological Testing (TPM, Chapter 7, Section 3.10).
- Respite Care (covered as part of ECHO) (TPM, Chapter 9, Section 12.1).
- SLP services (TPM, Chapter 7, Section 7.1).

5.2 Services for ASD covered under the ACD:

- Autism services coordination via the ASN.
- ABA services.

6.0 AUTISM SERVICES COORDINATION

The TRICARE Overseas Program (TOP) contractor, U.S. Family Health Plan Designated Providers (USFHP DPs), and TRICARE For Life (TFL) are excluded from paragraphs 6.0 through 6.9. Case management services in accordance with the contracts are otherwise not affected.

6.1 The contractor shall assign an autism-specific care manager, known as the ASN (see paragraph 11.11), to all new beneficiaries entering the ACD for ABA services on or after October 1, 2021, who will serve as the primary advocate for the beneficiary.

Note: "New beneficiaries" is defined as any beneficiary not currently receiving ABA services under the ACD as of the date of publication of this manual change. Current beneficiaries in the ACD who are transferring regions and continuing ABA services are not considered new. Additionally, any beneficiary

requesting ABA services after a gap in ABA services for any reason, for a period of 12 months or more, is considered a "new beneficiary" and all referral and authorization requirements, including the assigning of an ASN, apply.

6.1.1 The contractor shall provide the name and contact information of the assigned ASN in writing to the family.

6.1.2 The ASN shall make contact with the family to describe the ASN services prior to any ABA services being authorized.

6.1.3 The contractor may utilize a non-clinical outreach coordinator to assist families with identifying providers, support groups, and local level resources.

6.1.4 The ASN shall:

6.1.4.1 Take the lead role and coordinate with other Case Management (CM) activities when the beneficiary has a CM and an ASN.

6.1.4.2 Be assigned and serve as the primary point of contact for the beneficiary/family even when the beneficiary is eligible for services from the TRICARE Select Navigator.

6.1.4.3 Coordinate with the TRICARE Select Navigator.

6.2 Comprehensive Care Plan (CCP)

6.2.1 The ASN shall conduct an initial care management assessment, to develop a written CCP (see paragraph 11.20) in order to identify the needs of the beneficiary and family. Discharge/transition planning shall be addressed in the CCP upon a beneficiary's enrollment into the ACD.

6.2.2 The ASN shall complete the CCP within 90 calendar days of the family being assigned an ASN.

- The contractor shall, for CCPs not completed within 90 calendar days as a result of family/beneficiary noncompliance, suspend ABA services through the duration of the existing authorization or until the CCP is complete, whichever occurs first.

6.2.3 The ASN shall review and incorporate the results of all outcome measures into the CCP.

6.2.4 The ASN shall notify the medical home, PCM, and/or referring provider and parent/caregivers that the CCP has been established.

- The ASN shall share the CCP with the respective providers prior to the beneficiary receiving ABA services under the ACD.

6.2.5 The ASN shall update the CCP at least every six months to include updated outcome measures.

6.3 The ASN shall serve as a single Point of Contact (POC), in coordination with Military Medical Treatment Facility (MTF) CM (when applicable), readily accessible by phone or email (based on

beneficiary preference), during regular business hours for the respective geographic time zone in which the beneficiary resides, to assist the beneficiary/family with all questions from the beneficiary's family related to autism care and shall:

6.3.1 Coordinate medical and behavioral health services (PT, OT, SLP, etc.), MTF services (including coordination with the MTF CM), ECHO services (for ADFMs), Network PCM (if applicable), specialty providers, ABA services, EFMP coordinators, and other clinical services based on the CCP for the beneficiary and the family.

6.3.1.1 Ensure parent-mediated programs work in collaboration with other identified treatment goals as part of a CCP (paragraph 11.20) to ensure that program goals do not contradict one another.

6.3.1.2 Coordinate and participate in medical team conference meetings and document in the contractor online system a summary of the medical team conference calls. The ASN notes shall be available to the PCM and/or referring provider, and the government. Any provider may request a medical team conference, however, the ASN, or non-clinical outreach coordinator, shall coordinate the meeting.

6.3.2 Work with the family to coordinate services, treatments, and hours appropriate for the family and beneficiary and document all types of care in the CCP.

6.3.3 Facilitate continuity of care when a beneficiary in the ACD moves, their sponsor retires, or a provider becomes unavailable.

6.3.3.1 The incoming and outgoing ASNs shall be assigned concurrently for at least one month prior to and after transferring regions/markets.

Note: Assignment of a new ASN is dependent on the family or provider notifying the contractor of the pending move/transition.

6.3.3.2 The outgoing ASN shall actively communicate with the incoming ASN to ensure direct ASN to ASN case transfer occurs via telephone and secure e-mail, and shall include, but not limited to, ensuring that the current referrals transfer without requiring a new ASD diagnosing/referring provider appointment.

- The incoming ASN shall work with the family to ensure all ACD program requirements are met if there is missing information in the case transfer.

Note: Voluntary case management services are available upon request for beneficiaries registered in ECHO. These case managers can assist with continuity of care issues with current ACD beneficiaries who do not have an ASN.

6.3.3.3 The outgoing ASN shall forward to the incoming ASN all ACD related documentation, including, but not limited to, the CCP and outcomes measures within 10 calendar days of being notified that a beneficiary is transferring to a location under the jurisdiction of another contractor.

6.3.3.4 The incoming ASN or non-clinical outreach coordinator shall identify providers for care and services for the diagnosis of ASD at the new location prior to a move.

- The incoming ASN or non-clinical outreach coordinator shall assist with identifying available appointments with needed providers no more than two weeks prior to arrival as the contractor cannot guarantee provider availability for extended periods of time.

6.3.3.5 The contractor shall coordinate with the MTF or appointing center for appointments that are required or available within the MTF.

6.4 The ASN or non-clinical outreach coordinator shall identify and facilitate connections with local level resources that may benefit TRICARE eligible beneficiaries in the ACD to include, but not limited to, access to state Medicaid services, community services, respite care, support groups, etc.

6.4.1 The ASN or non-clinical outreach coordinator shall assist the family in accessing available respite service options, as well as assist in identifying necessary documents for the respective options.

6.4.2 All beneficiaries may be eligible for state and/or local level services.

6.4.3 ADFMs may also be eligible for Service/EFMP respite or TRICARE ECHO respite services, see TPM, Chapter 9, Section 12.1.

6.5 The ASN or non-clinical outreach coordinator shall provide educational resources about ASD to the beneficiary and/or family, including but not limited to, appropriate treatments and services, contractor provided parental education modules, available resources (both military and civilian), potential impact of the diagnosis of ASD on the family, and the potential long-term care required to support the beneficiary and help them reach their maximum potential.

6.5.1 The ASN or non-clinical outreach coordinator shall document that materials were received via acknowledgment by the family.

6.5.2 The contractor shall make resources available electronically on the contractor's website no later than October 1, 2021.

- The contractor shall also make this information available by mail or email if requested by the family.

6.6 The ASN shall provide beneficiary-specific outcome measures data to the respective TRICARE authorized rendering providers.

6.7 The contractor may employ or subcontract the ASN role.

Note: If subcontracted, the ASN must not provide any ASN services (see paragraph 6.0 through 6.9) to beneficiaries for whom they are rendering treatment services. The ASN role must be external to the agency rendering services to the beneficiary.

6.8 If a new beneficiary or the family, on or after October 1, 2021, declines the ASN for any reason, they are no longer eligible for the ACD.

6.8.1 The contractor shall document in the beneficiary file of any declination of ASN and coordinated ACD services.

6.8.2 Declining ACD services does not preclude Basic benefit services, just the coordinated ASN and ABA services. However, the beneficiary or family member can request to reengage in the ACD at any point provided all criteria are met. The beneficiary is considered a new beneficiary for purposes of the ACD if they reengage.

6.9 The contractor shall document ASN notes in the contractor's case management system that is visible to government designated authorities.

7.0 PARENTAL AND FAMILY SUPPORT

The TOP, USFHP DPs, and TFL contractors are exempt from paragraphs 7.1 through 7.1.5, however, the TOP and USFHP DP contractors shall provide support to families on an individual basis when engaged by the family.

7.1 The contractor shall make publicly available on the contractor website (see paragraph 9.3.1), and the ASN, when assigned, shall notify the family, about information and resources related to ASD that include but are not limited to:

7.1.1 Support groups and resources in the local area.

7.1.2 Support groups and services on military installations when available.

Note: Support groups are a community resource, not a TRICARE covered benefit.

7.1.3 A contractor-developed "New to the ACD information toolkit" (approved by DHA prior to use) that shall provide beneficiaries and their families with information about the ACD no later than October 1, 2021, including but not limited to ECHO enrollment, description of all services available to the beneficiary, the role of the ASN, what to expect every six months, one year, and two years if receiving services.

7.1.4 Mental health services (i.e., individual, family, and group) and non-clinical services (i.e., Military OneSource, etc.), in each local area that offer specialized services for family members of a beneficiary with a diagnosis of ASD (in accordance with paragraphs 6.3.1 and 6.4). Telehealth services may be leveraged for accessing appropriate mental health services (see TPM, Chapter 7, Section 22.1 regarding telehealth services).

7.1.5 Parent-mediated programs (see paragraph 11.24), rendered by TRICARE authorized individual providers under the Basic program, where available. Parent-mediated programs are reimbursed based on the TRICARE authorized individual provider's discipline for treatment (i.e., Licensed Clinical Social Workers (LCSWs) shall use Current Procedural Terminology (CPT) codes for individual/group/family psychotherapy sessions). All parent-mediated programs must meet all requirements for the Basic program.

8.0 ABA SERVICES

Under the demonstration authority, TRICARE covers clinically necessary and appropriate ABA services for the diagnosis of ASD only. ABA services are one component of a comprehensive array of services. Additionally, ABA providers are authorized to render only ABA services under the demonstration authority. The following paragraphs identify approved ABA services under the

demonstration:

8.1 ABA Services Benefit

ABA services for the diagnosis of ASD may be provided solely by a master's level or above authorized ABA supervisor and/or under the tiered delivery model, where an authorized ABA supervisor will plan, deliver, and supervise an ABA program. Both models are authorized and the model selected is based on the needs of the beneficiary. The Treatment Plan (TP) is based on which model is being implemented. See paragraphs 11.4 and 11.5 for definitions of sole and tiered delivery models.

8.2 ABA Provider Requirements

The contractor shall ensure that all TRICARE ABA provider requirements are met, and subsequently certified, prior to reimbursement of claims for any ABA services. All TRICARE ABA providers authorized under the ACD only (master's level and above, assistant, and BT level) must:

8.2.1 Obtain a National Provider Identifier (NPI) number (all claims must have the rendering provider's name and NPI for processing). For ABA providers who do not possess an NPI prior to July 1, 2021, these providers shall have until August 1, 2021 to obtain and submit an NPI. For ABA providers new to the ACD on or after July 1, 2021, providers must already possess an NPI at the time of certification application submission.

- TOP contractors shall follow Chapter 19, Section 4, paragraph 3.1 regarding provider identification.

8.2.2 Complete the training for Basic Life Support (BLS) or a Cardiopulmonary Resuscitation (CPR) equivalent certification, as demonstrated by completion of a hybrid course comprised of a web-based instruction component and live component to demonstrate skills on a dummy. Any course that is done entirely in person is also acceptable. This certification must be maintained and current.

8.2.3 The contractor shall obtain respective documents from the authorized ABA supervisor:

8.2.3.1 A copy of a Criminal History Review, as specified in Chapter 4, Section 1, paragraph 8.0, for all authorized ABA supervisors with whom the contractor enters into a Participation Agreement.

8.2.3.2 A copy of a Criminal History Background Check (CHBC) of assistant behavior analysts and BTs new to the demonstration on or after July 1, 2021.

8.2.3.3 The CHBC of assistant behavior analysts and BTs shall Include current Federal, State, and County Criminal and Sex Offender reports for all locations the assistant behavior analyst or BT has resided or worked during the previous 10 years new to the demonstration on or after July 1, 2021;

8.2.3.4 The TOP contractor shall obtain criminal history reviews and criminal history background checks in accordance with host nation laws and policies from the authorized ABA supervisor; and

8.2.4 Any provider who is convicted of any felony of any kind, or a misdemeanor involving crimes against a child or domestic violence is ineligible, to become a TRICARE authorized provider.

8.2.5 The contractor shall issue a provider certification after the review of a complete application packet that meets the requirements set forth in this section.

8.3 ACD-Corporate Services Providers (ACSPs) And Sole Providers

ACSPs include autism centers, autism clinics, and Sole Providers (regardless of setting of rendered ABA services, i.e., home or clinic). In many cases, ACSPs will have contractual agreements with individual assistant behavior analysts and BTs under their supervision to render ABA services. Autism schools are not authorized providers under the ACD. The ACSP including Sole Providers must:

8.3.1 Submit evidence to the contractor that professional liability insurance in the amounts of one million dollars per claim and three million dollars in aggregate, is maintained in the ACSP's/Sole Provider's name, unless state requirements specify greater amounts;

- TOP contractor shall ensure professional liability insurance is in accordance with the TOP contract.

8.3.2 Submit to the contractor all documents necessary to support an application for designation as a TRICARE ACSP/Sole Provider;

8.3.3 Enter into a Participation Agreement, Addendum A, approved by the Director, DHA or designee (i.e., the contractor). All ACSPs/Sole Provider practices prior to July 1, 2021 must re-sign all of their Participation Agreements no later than August 1, 2021 or risk terminating their TRICARE authorized status.

- The contractor shall submit a list of non-compliant providers. The Government retains final decision making for provider termination;

8.3.4 Employ directly or contract with qualified authorized ABA supervisors, assistant behavior analysts, and/or BTs, if applicable;

8.3.5 Certify that all authorized ABA supervisors, assistant behavior analysts, and BTs employed by or contracted with the ACSP meet the education, training, experience, competency, supervision, and ACD requirements specified in this section;

8.3.6 Comply with all applicable organizational and individual licensing or certification requirements that are extant in the State, county, municipality, or other political jurisdiction in which ABA services are provided under the ACD;

8.3.7 Maintain all applicable business licenses and employment or contractual documentation in accordance with Federal, State, and local requirements and the authorized ABA supervisor's business policies regarding assistant behavior analysts and BTs.

8.3.8 Report to the contractor within 30 calendar days of notification of a state sanction or BACB sanction issued to the BCBA or BCBA-Doctoral level (BCBA-D) for violation of BACB Professional and Ethical Compliance Code for Behavior Analysts (http://www.bacb.com/ethics-code) or notification of loss of BACB certification. Loss of state licensure or certification, or loss of BACB certification shall result in termination of the Participation Agreement with the authorized ABA supervisor with an effective date of such notification. Termination of the Participation Agreement by the contractor may be

appealed to DHA in accordance with the requirements of Chapter 12. While the Participation Agreement is with the ACSP/Sole provider, failure to remove the sanctioned provider will result in the termination of the entire ACSP or Sole provider group from the ACD.

8.3.9 Familiarize themselves with, and comply with program requirements as stated in 32 CFR 199.6 and 32 CFR 199.9. This information is available online and is accessible to the public. TRICARE Manuals and CFRs can be found online at https://manuals.health.mil/. All authorized ABA providers agree to abide by all rules and regulations of the TRICARE Program, but additionally agree to bill for services that are only deemed clinically necessary and appropriate.

8.3.10 Attend a contractor-hosted "provider education" training, no less than annually, beginning no later than October 1, 2021.

8.3.11 Comply with all applicable requirements of the Government designated utilization and clinical quality management organization.

8.4 Provider Requirements

8.4.1 Authorized ABA Supervisors (BCBA, BCBA-D, or Clinical Psychologist)

8.4.1.1 Have a master's degree or above in a qualifying field as defined by the state licensure/ certification where defined or in the absence of state licensure/certification, a graduate degree from an accredited institution (per TPM, Chapter 11, Section 3.3) in behavior analysis, psychology, special education, or a related field; and

8.4.1.2 Have a current:

8.4.1.2.1 Unrestricted state-issued license or state certification for full clinical practice if practicing in a state that offers state licensure or state certification in behavior analysis or psychology; or

8.4.1.2.2 Certification from the BACB where such state-issued license or certification is not available.

8.4.2 Assistant Behavior Analysts

8.4.2.1 Have a bachelor's degree or above in a qualifying field as defined by the state licensure/ certification where defined or in the absence of state licensure/certification, a degree in a field accepted by a certification body approved by the Director, DHA; and

8.4.2.2 Have a current:

8.4.2.2.1 Unrestricted state issued license or state certification if they practice in a state that offers state licensure or state certification; or

8.4.2.2.2 Certification from the BACB or the Qualified Applied Behavior Analysis (QABA) certification board.

Note: Should a state licensure or state certification specify criteria for an assistant behavior analyst that results in a previously authorized TRICARE assistant behavior analyst not meeting the requirements for state licensure or state certification, that provider may be recognized by TRICARE as only a BT without having to obtain the BT certification (if allowed by state law) and shall be subject to all BT requirements once the state licensure language becomes effective. A certification as an ABA provider must be maintained.

8.4.2.3 Assistant behavior analysts must receive supervision in compliance with their certification board. Assistant behavior analysts must work under the supervision of an authorized ABA supervisor who meets the requirements specified in paragraph 8.4.1.

8.4.2.4 Assistant behavior analysts who conduct supervision of BTs must be in compliance with their certification board for supervisory activities.

8.4.3 Behavior Technicians (BTs)

8.4.3.1 All BTs must possess a current Registered Behavior Technician (RBT), Applied Behavior Analysis Technician (ABAT), or Board Certified Autism Technician (BCAT) certification, or state certification, before applying for TRICARE-authorized provider status.

Note: Should a state licensure or state certification specify a BT certification type, that state designation must be followed.

8.4.3.2 The contractor shall certify a BT as a TRICARE provider within 10 business days from the receipt of a complete application that meets all requirements for certification.

8.4.3.3 BTs must receive ongoing supervision in compliance with their certification board.

8.5 ABA Provided Under The TRICARE Overseas Program (TOP)

8.5.1 The contractor shall ensure ABA services provided overseas shall follow all the requirements in this manual. While U.S. territories fall under TOP, tiered services (the use of assistants and BTs) may be authorized in U.S. territories only, and must follow all requirements laid out in this manual, including reimbursement rates (see http://www.health.mil/rates) for all ABA providers. The tiered model is not authorized outside of the U.S. and U.S. territories.

8.5.2 The TOP contractor shall verify compliance with all requirements outlined in the ACD.

8.5.3 Where there are no BCBAs or BCBA-Ds certified by the BACB within the TRICARE specialty care access standards in the host nation, there is no ABA benefit.

8.5.4 The contractor shall work with the TOP Office to identify the most appropriate claim form to use depending on the host nation country and the overseas provider's willingness to use the Centers for Medicare and Medicaid Services (CMS) 1500 Claim Form. See Chapter 24, Section 9, paragraph 1.6 for additional guidance.

8.5.5 The contractor shall ensure the reimbursement of TOP claims for ABA services obtained overseas shall be based upon the lesser of billed charges, the negotiated reimbursement rate, usual and customary charges, or the Government-directed reimbursement rate foreign fee schedule. (See

Chapter 24, Section 9 and the TRICARE Reimbursement Manual (TRM), Chapter 1, Section 35 for additional guidance).

8.6 ABA Policy

8.6.1 Referral for ABA Services

A complete referral for ABA services under the ACD is required for all TRICARE eligible beneficiaries in accordance with paragraph 4.0. Referral processing requirements are located in Chapter 1, Section 3. A retroactive referral will not be accepted.

8.6.1.1 A referral must specify ABA services are being requested.

8.6.1.2 For beneficiaries first diagnosed with ASD at age eight years or older, and requesting ABA services, on or after October 1, 2021, a specialized ASD diagnosing provider evaluation (not a PCM), meeting all diagnosis requirements set forth in paragraph 4.2, is required as part of the referral for ABA services.

8.6.1.3 The contractor shall collect an updated evaluation to determine the current level of supports needed, to include diagnostic criteria and a validated assessment tool, by an ASD diagnosing provider, if the initial diagnosis was made greater than two years prior to a referral for ABA services effective October 1, 2021.

8.6.1.4 The contractor shall align all new and existing beneficiaries to a chronological two year referral timeline, no later than July 1, 2021, from initial or most current verified referral, and notify the beneficiary/family of this date.

- The contractor shall use the referral receipt date confirmed by the contractor's system of the verified referral as the start date of the two-year referral timeline.

8.6.2 Authorization for ABA Services

8.6.2.1 The contractor shall, upon receipt of the completed referral for ABA services, issue an evaluation authorization for an initial assessment and TP development. The authorized ABA supervisor then completes and submits the initial documentation (assessment and TP) including recommended Adaptive Behavior Services (ABS) CPT codes and number of units to the contractor for review and subsequent appropriate approval for a six month treatment and reassessment/TP update authorization for active delivery of ABA services in accordance with Chapter 1, Section 3.

8.6.2.1.1 The contractor shall issue the treatment authorization identifying approved units in accordance with the guidance defined in paragraph 8.11.6.2.

8.6.2.1.2 The contractor shall issue an initial six-month treatment authorization only when all initial outcome measures are complete.

8.6.2.1.3 The contractor shall ensure all ABA services are preauthorized.

8.6.2.2 The contractor shall, no later than August 1, 2021:

8.6.2.2.1 Complete a clinical necessity review on every TP's recommended goals, targets, progress, and hours (see paragraph 8.7.1 for TP requirements) prior to issuing any six month treatment authorization for ABA services.

8.6.2.2.2 .Deny and return TPs containing exclusions as defined in paragraph 8.10.

8.6.2.2.3 Work with the ABA provider to revise the TP to address any findings requiring resolution prior to authorization of that TP.

8.6.2.3 Authorizations issued prior to August 1, 2021, and their associated claims remain active until the next authorization period. Revisions to the existing authorizations are not permitted.

8.6.2.4 The contractor shall complete 100% clinical necessity reviews of ABA services for all compliant TPs within the five business days for authorization processing standards.

8.6.3 Subsequent Referrals and Authorizations

8.6.3.1 If ongoing services are clinically indicated, prior to the expiration of each six-month treatment authorization period, as early as 60 calendar days in advance and no later than 30 calendar days in advance, a re-authorization for ABA services should be requested by the ABA provider for the next six months from the contractor. Should the ABA provider submit the reauthorization request less than 30 calendar days in advance of the expiring authorization, the ABA provider is at risk for non-reimbursable ABA services until the new authorization is issued if the existing authorization expires prior to the approval of the next authorization.

8.6.3.1.1 The contractor shall not back date late submissions.

8.6.3.1.2 The request for re-authorization must be supported by submission of the every six month ABA reassessment and TP update that includes documentation of progress. Outcome measures must be completed/submitted prior to issuing the next six-month treatment authorization.

8.6.3.1.3 The contractor shall complete a clinical necessity review of the documentation submitted every six months, including Pervasive Developmental Disorder Behavior Inventory (PDDBI) results and other treatment services the beneficiary is receiving.

8.6.3.1.4 The contractor shall work with the ABA provider to revise the ABA TP if the beneficiary is not making clinically sufficient progress as shown on the outcome measures prior to authorization.

8.6.3.1.5 The contractor shall issue subsequent treatment authorizations that meet the requirements set forth in this Section.

8.6.3.2 Every two years from the initial verified referral date, a new referral, with level of support, is required and must be submitted for ongoing ABA services. The new referral is not a new diagnostic evaluation, but rather a review of the beneficiary's progress, and update to the DSM criteria to include an update for the level of supports required. These subsequent referrals may be accepted up to six months in advance.

8.6.4 Outcome Measures

For all TRICARE eligible beneficiaries receiving ABA services, all outcome measures must be completed and reported, using norm-referenced, valid, and reliable evaluation tools prior to issuing the treatment authorization. For the purpose of the ACD, all outcome measures completed by ABA providers are considered an indirect service and to be completed under CPT code 97151 (see paragraph 8.11.6.2.1). Submission of all outcome measure results must include the full publisher print report or hand-scored protocol and summary score sheet(s). Imbedding scores within the treatment plan or other clinical documents is insufficient to meet the submission requirements.

8.6.4.1 PDDBI, Current Edition

8.6.4.1.1 This outcome measure must be completed using the standard or extended form at baseline and every six-months thereafter by the authorized ABA supervisor. The name of the respondent and relation to the beneficiary is required on all forms. Only the Parent Form is required at baseline. The Parent Form and the Teacher Form must be completed and submitted every six-months thereafter to align with the TP submission and reauthorization. The PDDBI must be completed and submitted by their respective deadlines. The Teacher Form must be completed by only the BCBA/BCBA-D. Responsibility for the completion of the Teacher Form by the BCBA/BCBA-D cannot be delegated. The Domain/Composite Score Summary Table, including all domain and composite scores, must be submitted to the contractor.

8.6.4.1.2 The contractor shall ensure all Domain and Composite scores are received, valid, and reported in the corresponding DD Form 1423, Contract Data Requirements List (CDRL) located in Section J of the applicable contract.

8.6.4.2 Vineland Adaptive Behavior Scales-3 (Vineland-3) (or Current Edition)

The Parent Form, the Interview Form (if completed by a TRICARE-authorized provider), or the Teacher Form are required. The name of the respondent and relation to the beneficiary is required on all forms. This measure is required at baseline and every year thereafter. See definition, paragraph 11.32.

8.6.4.3 Social Responsiveness Scale, 2nd Edition (SRS-2) (or Current Edition)

The Parent Form is required. The name of the respondent and relation to the beneficiary is required on all forms. This measure is required at baseline and every year thereafter. See definition, paragraph 11.29.

8.6.4.4 Parenting Stress Index, Fourth Edition (PSI-4) (or Current Edition) Required as of August 1, 2021

The Short Form is required. The name of the respondent and relation to the beneficiary is required. This measure is required at baseline and every six-months thereafter. See definition, paragraph 11.25.

Note: The TOP contractor is exempt from paragraph 8.6.4.4.

8.6.4.5 Stress Index for Parents of Adolescents (SIPA) Required as of August 1, 2021

The Profile Form is required. The name of the respondent and relation to the beneficiary is required. This measure is required at baseline and every six-months thereafter. See definition, paragraph 11.30.

Note: The TOP contractor is exempt from paragraph 8.6.4.5.

8.6.4.6 The contractor shall make available to treating providers of ACD beneficiaries all available outcome measures scores.

8.6.5 Medical Team Conference

8.6.5.1 Medical team conferences include face-to-face participation (in-person or via a compliant telehealth platform) by a minimum of three Qualified Health Care Professionals (QHPs) from different specialties or disciplines (each of whom provides direct services to the beneficiary), with or without the presence of the beneficiary/family member(s), who convene to collaborate or discuss a specific beneficiary case. The participants are actively involved in the development, revision, coordination, and implementation of health care services clinically necessary for the beneficiary. See paragraph 8.11.6.2.7 for requirements for using this CPT code. Though not required, family member/beneficiary participation, as appropriate, is recommended.

8.6.5.2 The ASN shall participate in these medical team conference discussions when an ASN is assigned per paragraph 6.0.

8.6.5.3 Participants must document their participation in the team conference as well as their contributed information and subsequent treatment recommendations in their medical documentation records.

8.6.5.4 No more than one individual from the same specialty may report this code at the same encounter.

8.6.5.5 Non-health care providers, i.e., school officials or an IEP meeting, are not counted as participants for this team conference. These individuals may be invited to participate in the medical team conference; however, these individuals are ineligible for reimbursement. Non-health care providers do not count toward the minimum of three QHPs for utilization of this service.

8.7 ABA Service Documentation

All ABA documentation must be completed according to the following:

8.7.1 ABA assessments and TP documentation (completed by the authorized ABA supervisor) must include:

8.7.1.1 Identifying Information

The beneficiary's name, date of birth, date the initial ABA assessment and initial ABA TP were completed, the beneficiary's DoD Benefit Number (DBN) or sponsor's Social Security Number (SSN), and the name of the referring provider;

8.7.1.2 Reason for Referral

The ABA TP and TP updates must include the ASD diagnosing/referring provider's ASD diagnosis, to include symptom severity level/level of support required according to DSM-5 ASD criteria.

8.7.1.3 Background Information

Background and history to include, but is not limited to, information that clearly reports the beneficiary's condition, diagnoses, medical co-morbidities (to include over-the-counter (OTC) medications), family history, school enrollment status, number of hours enrolled in school, the number of hours receiving other support services such as OT, PT, and SLP, documentation of the age of the child and year of the initial ASD diagnosis, and how long the beneficiary has been receiving ABA services.

8.7.1.4 Summary of Assessment Activities

The TP must include objectively measured behavioral excesses and deficits that impede the beneficiary's safe, healthy, and independent functioning in all domains applicable (language, development, social communication, and clinical adaptive behavior skills). This assessment may indicate a need for a behavior intervention plan (paragraph 11.6) for each target behavior excess and deficit. The TP shall include the list of assessments administered. The initial ABA assessment must include the PDDBI Parent Form Domain/Composite Score Summary Table.

8.7.1.5 TP Goals

The ABA TP must clearly define measurable targets in all relevant DSM-5 (or most current edition) symptom domains, including parent/caregiver goals as identified in the initial assessment, and objectives and goals individualized to the strengths, needs, and preferences of the beneficiary and his/her family members. The ABA TP goals must address core symptoms of ASD:

- Social Communication and Social Interaction Behavior (to include restricted, repetitive, and/or stereotypical patterns of behavior, interests, and/or activities);
- Restrictive/Repetitive/Stereotypical Patterns of Behavior (i.e., stereotyped/ repetitive motor movements, insistence on sameness, inflexible adherence to routines, highly fixated interests, hyper/hypo-activity to sensory input).

8.7.1.5.1 Goals must be measurable, objective, achievable, developmentally appropriate, and clinically significant.

8.7.1.5.2 Goals must be described as follows:

- Objective, baseline and ongoing measurement levels for each target behavior/symptom in terms of frequency, intensity, and duration;
- A description of treatment interventions and techniques specific to each of the targeted behaviors/symptoms;
- Identify the objective measures of assessment for each goal specified; and

- Functional goals must be specific to the beneficiary, objectively measurable within a specified time frame, attainable in relation to the beneficiary's prognosis and developmental status, relevant to the beneficiary and family, and directly related to the core symptoms of ASD as defined by the DSM.

8.7.1.5.3 The ASN, when assigned, shall ensure goals typically treated by specialty providers are identified and addressed in the CCP. When developing goals for beneficiaries with suspected or diagnosed co-morbid medical or behavioral health conditions, the authorized ABA supervisor must coordinate with the appropriate skilled and licensed professionals in order to assess the most appropriate treatment intervention. In order for the authorized ABA provider to address co-morbid condition targets, documentation on the TP must demonstrate coordination with the appropriate medical specialty services, to include the name of the consulting provider. For example:

8.7.1.5.3.1 A beneficiary with a co-morbid diagnosis of a motor disorder who has TP goals addressing speech or motor skill development would require coordination with SLP, OT, or PT as appropriate.

8.7.1.5.3.2 A beneficiary with a co-morbid diagnosis of anxiety disorder would require coordination with the appropriate behavioral health provider.

8.7.1.5.3.3 A beneficiary with a feeding disorder would require coordination with the appropriate medical provider to include but not limited to: physician, dietitian, OT, or SLP.

8.7.1.6 TP ABA Services Recommendations

TP recommendations of units of ABA services are based on a combination of: the DSM-5 (or most current edition) symptom domains and levels of support required per DSM-5 ASD criteria, results of outcome measures (for TP updates), and the capability of the beneficiary to participate actively in ABA services. A recommendation for the number of hours, submitted as units, of all relevant ABA services (see CPT codes for all covered services) under the ACD must be included. If recommended units (hours) are not being rendered, then an explanation (i.e., family availability, family preference, BT turnover, etc.) is required to be documented in the subsequent TP.

8.7.1.6.1 A recommendation for the number of monthly hours, submitted as units, and measurable objectives and goals for parent/caregiver treatment guidance on implementation of selected treatment protocols with the beneficiary at home and in other settings where applicable is required. Participation by the parent(s)/caregiver(s) is required, and re-authorization for ABA services is contingent upon their involvement. If parent(s)/caregiver(s) participation is not possible, the TP must document the reasons for non-participation (i.e., the parent/caregiver is deployed, is physically unable to deliver the ABA services, etc.). All attempts to mitigate the lack of involvement/participation must be documented by the ABA provider. Implementation of the TP should begin with parent guidance sessions (CPT code 97156 or 97157), especially if other ABA services are delayed because the authorized ABA supervisor is hiring a new BT for the TP.

8.7.1.6.2 TP must identify recommended units for each requested CPT code including the location of rendered services.

8.7.1.6.3 Documentation of parent/caregiver engagement and implementation of the ABA TP must be included as a required TP goal that is reassessed every six months during the ABA TP update. Reasons for lack of/inability for parental involvement must be documented.

8.7.1.6.4 Recommendation for continued ABA services (if continuation is indicated) to include a recommendation for the number of weekly units of one-on-one ABA services, including documentation of clinical necessity if additional units are required.

8.7.1.7 TP Progress

ABA reassessments and TP updates must document the evaluation of progress for each current behavior target identified on the initial ABA TP and prior TP updates. Documentation of the ABA reassessment and TP update must be completed every six months and include all of the following but not limited to (the contractor may request additional information based on best practices):

8.7.1.7.1 Date and time the reassessment and TP update was completed.

8.7.1.7.2 ABA provider conducting the reassessment and TP update.

8.7.1.7.3 Evaluation of progress on each treatment target (i.e., Met, Not Met, Discontinued).

8.7.1.7.4 Description of progress toward short and long-term treatment goals for the identified targets in each domain utilizing either graphic representation of ABA TP progress or an objective measurement tool consistent with the baseline assessment. Documentation should identify interventions that were ineffective and required modification of the TP. TP updates must document TP modifications that were the result of the outcome evaluations.

8.7.1.7.5 Revisions to the ABA TP must include identification of new behavior targets, objectives, and goals, to include TP modifications based on the cumulative six month assessment of the PDDBI and other outcome measures evaluation.

8.7.1.7.6 The contractor shall engage the authorized ABA supervisor to review the TP if no progress has been made and the provider must incorporate revisions to the individual TP to address the lack of progress.

8.7.1.8 Signatures

The ABA TP and TP updates must contain signatures by the authorized ABA supervisor, and the parent/caregiver to ensure the parent/caregiver is fully cognizant of the care being provided to their child.

8.7.1.9 The reassessments, to include the completion of the PDDBI, and TP updates are required every six months (one assessment for each authorization period) and must be dated as being conducted during that time frame. Reassessments must be completed and submitted no later than 30 calendar days prior to the end of the current authorization for review for re-authorization. Any delay in submission of the ABA reassessment and TP updates may delay the subsequent authorization for ABA services.

8.7.2 Progress Note Documentation

In addition to TPM, Chapter 1, Section 5.1, "Requirements for Documentation of Treatment in Medical Records," progress note documentation must contain the following documentation elements for each CPT code session:

8.7.2.1 Beneficiary's full name (not initials);

8.7.2.2 The date and time of session to include start and end time;

8.7.2.3 Location of rendered services;

8.7.2.4 Length of session;

8.7.2.5 A legible name of the rendering provider, to include provider type/level;

8.7.2.6 A signature of the rendering provider with the date signed;

8.7.2.7 Name of authorized ABA supervisor;

8.7.2.8 Name of all session participants (excluding other beneficiaries in CPT codes 97157 and 97158);

8.7.2.9 A notation of the patient's current clinical status evidenced by the patient's signs and symptoms;

8.7.2.10 Narrative content of the session (group session (see paragraphs 8.11.6.2.5 and 8.11.6.2.6) may contain a common summary);

8.7.2.11 A statement summarizing the techniques attempted during the session;

8.7.2.12 Narrative description of the response to treatment, the outcome of the treatment, and the response to significant others (group session notes must contain individualized responses to treatment);

8.7.2.13 A narrative statement summarizing the patient's degree of progress towards the treatment goals;

8.7.2.14 Each section of the progress note documentation must be individualized to the beneficiary and each session, and

8.7.2.15 Effective January 1, 2019, the final product for CPT code 97151 must be in the format of a TP. However, all encounters using CPT code 97151 must document a progress note. This progress note must include, but is not limited to:

- The date and time of session to include start and end time;
- Length of assessment session;

- A legible name of the rendering provider, to include provider type/level;
- A signature of the rendering provider;
- Content of the session to include what activity, measures, observations were administered during the assessment.

8.8 Discharge Planning

8.8.1 The following discharge criteria are established to determine if/when ABA services are no longer appropriate:

8.8.1.1 Loss of eligibility for TRICARE benefits as defined in 32 CFR 199.3.

8.8.1.2 The authorized ABA supervisor, the contractor, or the family has determined one or more of the following:

- The patient has met ABA TP goals and is no longer in need of ABA services.
- The patient has made no measurable progress toward meeting goals identified on the ABA TP after successive progress review periods and repeated modifications to the TP.
- ABA TP gains are not generalizable or durable over time and do not transfer to the larger community setting after successive progress review periods and repeated modifications to the TP.
- Recommended by the contractor through the clinical necessity review process.
- The patient can no longer participate in ABA services (due to medical problems, family problems, or other factors that prohibit participation).

8.8.1.3 Termination of services if the diagnosing/referring provider or PCM either changes the diagnosis, or does not believe continued ABA services are clinically necessary.

8.8.2 Termination of ABA services under any circumstance must not occur abruptly by the authorized ABA supervisor. All termination plans must be at least 45 calendar days prior to the termination of services.

8.8.2.1 The contractor shall work with the ABA provider to ensure a smooth transition when services are determined to no longer be clinically necessary or otherwise need to be terminated on short notice.

8.8.2.2 The contractor shall, should ABA services be terminated abruptly by the authorized ABA supervisor, report the authorized ABA supervisor to the appropriate credentialing/licensure board.

8.8.3 The contractor shall, if the clinical necessity review determines direct ABA services, either one to one or group, are no longer clinically necessary, approve parent training services to fade an ABA service program for one six-month authorization.

8.8.4 Discharge planning must be documented in every initial TP, every updated TP, and at termination of services.

8.8.5 A discharge summary from the treating authorized ABA supervisor is required for all beneficiaries whose ABA services are terminated to include the reason for termination. Discharge summary writing is not a reimbursable service as this is an indirect activity (report/summary writing).

8.9 ABA Quality Monitoring and Oversight

8.9.1 This demonstration is subject to existing program requirements for quality monitoring and oversight.

8.9.2 The contractor shall conduct, on an annual basis, an audit, which must include a minimum of 30 records for each ASCP/Sole provider group that include a combination of administrative records (paragraph 8.9.7) and medical documentation (paragraph 8.9.8) reviews and one medical team conference progress note.

8.9.3 The TOP and USFHP contractor shall conduct, on an annual basis, an audit, which must include a minimum of 10% of records for each ASCP/Sole provider group that include a combination of administrative records (paragraph 8.9.7) and medical documentation (paragraph 8.9.8) reviews and one medical team conference progress note.

8.9.4 The contractor shall conduct outreach and education to ACSP/Sole Provider groups with inconsistencies or errors identified in the annual audits.

8.9.5 The contractor shall initiate progressively more severe administrative action, commensurate with the seriousness of the identified problems, and consistent with Chapter 13 and 32 CFR 199.9.

8.9.6 The contractor shall recoup all claims determined to be insufficient for claims payment.

8.9.7 Administrative Claims Review

8.9.7.1 The contractor shall target detection and prevention efforts of services that pose the greatest risk of fraud and abuse to the TRICARE program and beneficiaries, to include a review of suspect billing practices and document risks to determine improper payments in the ACD program.

8.9.7.2 The contractor shall review ACD claims which may include at a minimum, but are not limited to:

- High-dollar, erratic, or inconsistent billing and coding patterns.
- Changes in billing frequency.
- Concurrent billing (i.e., billing for two services at the same time).
- Misrepresentation of provider (i.e., filing for a non-rendering provider or non-authorized provider).

- Claims patterns of "impossible days" (provider's total claims exceed 12 hours per any given calendar day).

- Patterns of high claim error rates.

8.9.7.3 The contractor shall provide education to each ACSP/Sole provider groups if suspect billing patterns are identified to address the findings and corresponding program requirements.

8.9.7.3.1 The contractor shall, no later than 180 calendar days following education, conduct a post-payment review of the Sole Provider or ACSP provider groups to determine if suspect billing patterns have improved.

8.9.7.3.2 The contractor shall, if suspect billing has not improved, refer the Sole Provider or ACSP provider group to the contractor's Program Integrity department for review.

8.9.8 Medical Records Documentation Review - Clinical and Non-Clinical Documentation

8.9.8.1 The contractor shall review ABA session documentation notes to ensure, include at a minimum, but not limited to:

- Compliance with the requirements set forth in paragraph 8.7.2.

- Compliance with ABS approved CPT codes per paragraph 8.11.6.

- Sufficient documentation to justify a medical record.

- No billing for office supplies to include therapeutic supplies.

- No billing for ABA services using aversive techniques to include restraints (even if billed using a covered CPT code).

- Group ABA services are not billed as authorized one-on-one ABA services.

- No billing for educational or vocational ABA services, and other non-medical services such as changing of diapers or billing for services while the beneficiary is sleeping.

- See exclusions (paragraph 8.10) for additional activities that are prohibited.

8.9.8.2 Clinical content reviews shall be completed by clinical staff.

8.9.8.3 The contractor shall educate and monitor providers with identified insufficiencies in clinical documentation for a minimum of six months but not later than 12 months.

8.9.8.4 The contractor shall conduct a probe audit sample (see Chapter 13, Section 3, paragraph 3.2.1) on these identified providers to review medical record documentation progress.

8.9.8.5 The contractor shall place any ABA provider who has not improved after a minimum of six months, but no later than 12 months of education and monitoring on pre-payment review.

8.9.9 New ACSP/Sole Provider Review

8.9.9.1 The contractor shall monitor all new ACSP/Sole providers entering the ACD program after July 1, 2021 for administrative and medical records documentation review.

8.9.9.2 The contractor shall conduct a probe audit sample (see Chapter 13, Section 3, paragraph 3.2.1) following 180 days of participation in the program to review clinical documentation and claims submission for consistency with program requirements.

8.9.9.3 The contractor shall share results of the probe audit with the new ACSP/Sole Provider, and provide education to address inconsistencies with program requirements.

8.9.10 Annual Reviews

The contractor shall conduct an annual audit of a statistically valid number of providers, to include collecting proof of documentation (either through source verification or actual document), to ensure ABA providers meet the requirements set forth in paragraphs 8.2 through 8.4.

8.10 Exclusions

The contractor shall not reimburse for, to include but not limited to:

8.10.1 Training of BTs.

8.10.2 ABA Services for any other diagnoses other than ASD.

8.10.3 ABA services are not covered for symptoms and/or behaviors that are not part of the core symptoms of ASD (i.e., impulsivity due to ADHD, reading difficulties due to learning disability, excessive worry due to anxiety disorder, etc.).

8.10.4 Billing for e-mails and phone calls.

8.10.5 Billing for driving to and from ABA services appointments (i.e., beneficiary's house, clinic, or other locations). Mileage/time traveling is not to be billed to the TRICARE program.

8.10.6 Billing for report writing outside of what is included in the assessment code (CPT code 97151).

8.10.7 Billing for office supplies or therapeutic supplies (i.e., binders, building blocks, stickers, crayons, etc.).

8.10.8 Billing for ABA services provided remotely through Internet technology or through telemedicine/telehealth (except as allowed under paragraph 8.11.6.2.4.9).

8.10.9 Billing for asynchronous telehealth services.

8.10.10 Rendering and billing for ABA services involving any aversive techniques or restraints.

8.10.11 Billing for services outside of the home, clinic, office, school, or telehealth. Certain community settings such as sporting events, camps, and other setting as determined by the contractor are also excluded. Any location not listed must be reviewed and approved by the contractor.

8.10.12 Billing for ABA services while the beneficiary is at another medical appointment to include another family member's appointment.

8.10.13 Educational/academic and vocational rehabilitation. All educational/academic and vocational goals must be removed from the TP prior to approval by the contractor.

8.10.14 Educational ABA services, such as services typically provided through a school curriculum.

8.10.15 TRICARE ABA services are not authorized in the school setting as a shadow, aid, or support to the beneficiary. ABA services in the school setting are limited to the role of the BCBA who is targeting a specific behavior excess or deficit and is for a limited duration. Any ABA services requested for the school setting must be specifically preauthorized in the TP for use in the school setting.

8.10.15.1 The contractor shall authorize and reimburse only CPT code 97153 rendered by the authorized ABA supervisor (not delegated to the assistant or BT) in the school setting.

8.10.15.2 After May 1, 2021, authorizations with approved BT services in the school setting will run through the end of the current authorization. However, no new authorizations for BTs in school setting will be approved after May 1, 2021.

8.10.16 ABA services for a beneficiary that are written in a beneficiary's IEP and required to be provided without charge by the local public education facility in accordance with the Individuals with Disabilities Act or other applicable laws and regulations. In order for ABA services to be authorized within a school setting, the parent/caregiver must voluntarily provide the IEP (or equivalent for non-public school placement) in order for the contractor to make an appropriate determination.

8.10.17 Billing for school tuition.

8.10.18 Autism schools are not TRICARE authorized providers. If an Autism school has a clinic setting as part of their offered services, the clinic must have a separate tax ID number.

8.10.19 Goals targeting functional/activities of daily living (ADLs) skills (see 32 CFR 199.2 definitions of ADLs) are excluded. However, the principles of ABA (i.e., backward chaining, schedules of reinforcement, etc.) may be targeted as a goal of parent/caregiver guidance to introduce how the parent should teach ADLs outside of ABA services rendered by an ABA provider.

8.10.20 Rendering or billing for custodian, personal care, and/or child care.

8.10.21 Durable Equipment (DE) whose safety and efficacy have not been established as described in 32 CFR 199.4.

8.10.22 Billing of direct and indirect supervision of BTs and assistant behavior analysts.

8.10.23 Billing of ABA evaluation or intervention services provided by a clinic or agency owned by the beneficiary's immediate family member (e.g., biological, adoptive, or foster parents, guardians, court-appointed managing conservators, other family members by birth or marriage).

8.10.24 Billing an ABA evaluation or intervention services provided directly by the beneficiary's responsible adult (e.g., biological, adoptive, or foster parents, guardians, court-appointed managing conservators, other family members by birth or marriage). Billing for rendered ABA services by family members is considered a conflict of interest and therefore may be subject to the Civil Money Penalties Law (CMPL).

8.10.25 Under the ACD, concurrent billing is excluded for all ABS Category I CPT codes except when the family and the beneficiary are receiving separate services and the beneficiary is not present in the family session.

8.10.26 Rendering or billing for any two ABA providers at the same time.

8.10.27 Rendering or billing any interventions considered psychotherapy to include but not limited to: Cognitive Behavior Therapy, Acceptance and Commitment Therapy, Prolonged Exposure, group psychotherapy, etc.

8.10.28 ABA providers rendering and billing for non-ABA services.

8.11 Reimbursement

8.11.1 Network and non-network provider claims for ABS CPT codes must be submitted electronically.

8.11.2 The contractor shall pay all claims by electronic funds transfer.

- For TOP claims payment, see Chapter 24, Section 9.

8.11.3 The contractor shall reimburse claims using the ABS CPT codes. These codes apply to the provision of ABA services rendered by ACD approved providers in all authorized settings (clinic, school, home, TH, or certain community setting).

8.11.4 The contractor shall ensure paid claims identify the name of the rendering provider for each ABA service delivered, to include the NPI (see paragraph 8.2.1 for NPI requirements) of the rendering provider per unique claim line (i.e., every session must be identified as its own unique line on any claim submitted).

8.11.5 Application of Health Insurance Portability and Accountability Act (HIPAA) taxonomy designation. All claims for ABS CPT codes must include the HIPAA taxonomy designation of each provider type. Each provider on a claim form must be identified by the correct HIPAA taxonomy designation. The designations to be used are:

- 103K00000X Behavior Analyst for master's level and above;
- 106E00000X Assistant Behavior Analyst;
- 106S00000X Behavior Technician; or
- Other appropriate HIPAA taxonomy based on license/certification

8.11.6 ABS Approved CPT Codes

The contractor shall only authorize ABS codes for only ABA providers under the demonstration authority using a special processing code.

8.11.6.1 Healthcare Common Procedure Coding System (HCPCS) T1023 - Outcome Measures Submitted By BCBA/BCBA-D (For authorizations issued prior to August 1, 2021)

This code is used by only the BCBA/BCBA-D for the purpose of reimbursement for submission of required data for the ACD outcomes measures (Vineland-3, SRS-2, and PDDBI). See paragraphs 8.6.4.2 and 8.6.4.3 for submission requirements and required data elements. For outcome measures administered via telehealth, claims must include the modifier GT or 95. Additionally, all approved ABA services provided via telehealth must adhere to state laws governing telehealth services.

8.11.6.2 Category I CPT Codes (For Dates of Service Beginning January 1, 2019)

Concurrent billing is excluded for all ACD Category I CPT codes except when the family and the beneficiary are receiving separate services and the beneficiary is not present in the family session. Existing authorization prior to August 1, 2021, run through the end of their current authorization period end date. The next authorization must incorporate the changes set forth below.

8.11.6.2.1 CPT Code 97151 - Behavior Identification Assessment

8.11.6.2.1.1 The initial ABA assessment, ABA TP development, and the ABA reassessments and TP updates, conducted by the authorized ABA supervisor during a one-on-one encounter with the beneficiary and parents/caregivers, must be coded using CPT code 97151, "Behavior Identification Assessment."

8.11.6.2.1.2 Elements of ABA assessment include:

- One-on-one observation of the beneficiary (must be completed in person, face-to-face).
- Obtaining a current and past behavioral functioning history, to include functional behavior analysis if appropriate.
- Reviewing previous assessments and health records.
- Conducting interviews with parents/caregivers to further identify and define deficient adaptive behaviors.
- Administering assessment tools, to include the administration of the PDDBI.
- Interpreting assessment results.
- Development of the TP, to include design of instructions to the supervised assistant behavior analysts and/or BTs (under the ACD).
- Discussing findings and recommendations with parents/caregivers.

- Preparing the initial ABA assessment, semi-annual ABA re-assessment (to include progress measurement reports), initial ABA TP and semi-annual ABA TP updates.

8.11.6.2.1.3 This code is intended for reporting initial assessments and reassessments by the authorized ABA supervisor once every six months.

8.11.6.2.1.4 CPT code 97151 is a timed code (per 15 minutes), meaning this code is reimbursed per authorized units provided by an authorized ABA supervisor (or as delegated to an assistant behavior analyst).

8.11.6.2.1.5 CPT code 97151 may not be conducted via telehealth.

8.11.6.2.1.6 The contractor shall, for services rendered prior to August 1, 2021, authorize CPT code 97151 for 16 units (four hours) for the initial request of ABA services to complete an initial ABA assessment and TP development.

8.11.6.2.1.7 The contractor shall, for services rendered on a new or approved TP on or after August 1, 2021, authorize CPT code 97151 for up to 32 units (eight hours) for the initial request of ABA services to complete an initial ABA assessment and TP development (to include administration, scoring, and review of the PDDBI). CPT code 97151 must be used within 14 calendar days of the first date of service for CPT code 97151 and is a use or lose concept.

8.11.6.2.1.8 The contractor shall, after the initial assessment, authorize CPT code 97151 for up to 24 units (six hours) for reassessments and TP updates for every subsequent authorization.

8.11.6.2.1.9 The contractor may authorize one additional unit of indirect CPT code 97151 per measure for providers that complete the Vineland, the SRS, and the PSI/SIPA, when prior authorized.

8.11.6.2.1.10 A second opinion authorization (for 32 units of CPT code 97151) may be permitted to overlap with another approved authorization. Two "ongoing" treatment authorizations of direct service (CPT codes 97153, 97155, 97156, 97157, and 97158) are not permitted.

8.11.6.2.2 CPT Code 97153 - Adaptive Behavior Treatment by Protocol

8.11.6.2.2.1 The code, CPT code 97153, must be used for direct one-on-one ABA services delivered per ABA TP protocol to the beneficiary. Direct one-on-one ABA services are most often delivered by the supervised BT or assistant behavior analyst under the tiered delivery model, but they can also be delivered by the authorized ABA supervisor under the sole provider or tiered delivery model.

8.11.6.2.2.2 CPT code 97153 is a timed, 15 minutes, increment code.

8.11.6.2.2.3 The contractor shall not, for new and approved TPs on or after August 1, 2021, authorize CPT code 97153 for greater than 32 units (eight hours) per day or 160 units (40 hours) per week without a clinical necessity review for determination.

8.11.6.2.2.4 CPT code 97153 may not be conducted via telehealth.

8.11.6.2.3 CPT Code 97155 - Adaptive Behavior Treatment by Protocol Modification

8.11.6.2.3.1 The code, CPT code 97155, is used by authorized ABA supervisors (or as delegated to an assistant behavior analyst) for direct one-on-one time with one beneficiary to develop a new or modified protocol. This code may also be used to demonstrate a new or modified protocol to a BT with the beneficiary present. The focus of this code is the addition or change to the protocol.

8.11.6.2.3.2 CPT code 97155 is a timed, 15-minute, increment code.

8.11.6.2.3.3 CPT code 97155 must be completed at least one time per month by the authorized ABA supervisor.

- The contractor shall complete a post-claims payment review, and if this requirement is not met, a 10% penalty on all ABA claims for that beneficiary shall be recouped for the entire six-month authorization.

8.11.6.2.3.4 The contractor shall not authorize for greater than eight units (two hours) per day.

Note: Team meetings and supervision of any type are not reimbursable under CPT code 97155.

8.11.6.2.4 CPT Code 97156 - Family Adaptive Behavior Treatment Guidance

8.11.6.2.4.1 It is important that family members or caregivers learn to apply the same treatment protocols to reduce maladaptive behaviors and reinforce appropriate behavior. It is expected that as families become more capable of providing treatment protocols or as beneficiary symptoms improve, the amount of one-on-one ABA services provided by an ABA provider will decrease. Unless therapeutically contraindicated, the family and/or guardian must actively participate in the continuing care of the beneficiary. Documentation of contraindication must be documented in the TP for continued eligibility for the ACD.

8.11.6.2.4.2 The code, CPT code 97156, is used by the authorized ABA supervisor for guiding the parents/caregivers to utilize the ABA TP protocols to reinforce adaptive behaviors. Authorized ABA supervisors may delegate family/caregiver guidance to assistant behavior analysts working under their supervision but only the authorized ABA supervisor may bill for this service using this code.

8.11.6.2.4.3 The beneficiary is not required to be present for the parent/caregiver sessions; however, presence of the beneficiary is encouraged.

8.11.6.2.4.4 CPT code 97156 is a timed, 15-minute, increment code.

8.11.6.2.4.5 The contractor shall not authorize CPT code 97156 for greater than eight units (two hours) per day.

8.11.6.2.4.6 CPT code 97156 may be used only in a home or clinic/office-based setting. School settings are prohibited.

8.11.6.2.4.7 For new and approved TPs on or after August 1, 2021, a minimum of six parent/caregiver sessions are required every six months. These six sessions may include CPT codes 97156, 97157, or a combination of the two.

8.11.6.2.4.7.1 The contractor shall work with the family and the provider to resolve barriers for parent/caregiver sessions. The first session shall be within the first 30 calendar days of the treatment authorization.

8.11.6.2.4.7.2 The contractor shall not, if this requirement is not met for two consecutive authorization periods, renew ABA services for a subsequent authorization period for that beneficiary.

8.11.6.2.4.8 For new and approved TPs on or after August 1, 2021, parent/caregiver sessions for CPT code 97156 may be conducted via telehealth only after the first six-month authorization period per authorized provider. Additionally, all services provided via telehealth must adhere to state laws governing telehealth services.

8.11.6.2.4.9 For new and approved TPs on or after August 1, 2021, parent/caregiver sessions conducted remotely must include the GT and 95 modifier when submitting claims. Remote Family Adaptive Behavior sessions must be in compliance with TPM, Chapter 7, Section 22.1.

8.11.6.2.5 CPT Code 97157 - Multiple-Family Group Adaptive Behavior Treatment Guidance (Beginning August 1, 2021)

8.11.6.2.5.1 It is important that parents or caregivers learn to apply the same treatment protocols to reduce maladaptive behaviors and reinforce appropriate behavior. This code is used by the authorized ABA supervisor (or as delegated to an assistant behavior analyst) for guiding the parents/caregivers to utilize the ABA TP protocols. This code is to be used for identifying behavior excesses and deficits, and teaching parent(s)/caregiver(s) to utilize treatment protocols designed to reduce maladaptive behaviors and/or skill deficits in a group setting. This code is not authorized for a support group or group psychotherapy. The beneficiary should not be present for the multi-family parent/caregiver sessions.

8.11.6.2.5.2 Groups must not exceed eight participants (i.e., each individual parent/caregiver, or pair of parents/caregivers, counts as one participant and only one claim may be filed per beneficiary).

8.11.6.2.5.3 The contractor shall recoup all claims for groups that exceed eight participants.

8.11.6.2.5.4 CPT code 97157 may only be used in a clinic/office-based setting.

8.11.6.2.5.5 CPT code 97157 may not be conducted via telehealth.

8.11.6.2.5.6 CPT code 97157 is a timed, 15-minute, increment code.

8.11.6.2.5.7 The contractor shall not authorize CPT code 97157 for greater than six, 15-minute units (1.5 hours) per day.

8.11.6.2.6 CPT Code 97158 - Group Adaptive Behavior Treatment by Protocol Modification (Beginning August 1, 2021)

8.11.6.2.6.1 The code, CPT code 97158, is used by the authorized ABA supervisor to beneficiaries in a group setting. The focus of the skills group will be to address specific measurable goals to address targeted social deficits and problem behaviors utilizing various techniques (e.g., modeling, rehearsing,

corrective feedback). The authorized ABA supervisor must adjust the level of assistance (e.g., prompts) given to each member based on their skill level and ongoing progress in the group.

8.11.6.2.6.2 CPT code 97158 must only be used when the beneficiary's TP identifies goals targeted for generalization of mastered skills. As beneficiaries demonstrate generalized skills, it would be expected that one to one services decrease as group services increase, then ABA services fade altogether.

8.11.6.2.6.3 Groups must not exceed eight participants.

8.11.6.2.6.4 The contractor shall recoup all claims for groups that exceed eight participants.

8.11.6.2.6.5 CPT code 97158 may not be conducted via telehealth.

8.11.6.2.6.6 CPT code 97158 is a timed, 15-minute, increment code.

8.11.6.2.6.7 The contractor shall not authorize CPT code 97158 for greater than six, 15-minutes units (1.5 hours) per day.

8.11.6.2.7 CPT Codes 99366 and 99368 Medical Team Conference (Beginning August 1, 2021)

8.11.6.2.7.1 CPT codes 99366 and 99368 are permitted only via face-to-face either in person or through the telehealth platform. Telephone-only is not permitted for providers.

8.11.6.2.7.2 CPT code 99366 Medical team conference with patient by healthcare professional.

8.11.6.2.7.3 CPT code 99368 Medical team conference without patient by health care professional.

8.11.6.2.7.4 The following criteria must be met to report and be reimbursed for the medical team conference codes:

- A minimum of three QHPs from different specialties or disciplines who provide direct care to the patient must participate in the reported team conference.
- No more than one individual from the same specialty may report CPT codes 99366 and 99368 at the same encounter.
- Reporting participants must be present for the entire medical team conference.
- Reporting participants must have performed face-to face evaluations or treatments of the patient, independent of any medical team conference, within the previous 60 calendar days.

Note: Additionally, the ASN must be present, when assigned, via TH or telephone, for provider reimbursement of the medical team conference.

8.11.6.2.7.5 Reporting participants should record and document their role in the conference, contributed information, and subsequent treatment recommendations. The time for the medical team

conference starts at the beginning of the case review and ends at the conclusion of the review. Record keeping or report generation time is not included.

8.11.6.2.7.6 The contractor shall issue one unit of CPT code 99366 and one unit of CPT code 99368 on each six-month treatment authorization for the ABA provider to participate in a medical team conference.

8.11.6.2.7.7 ABA providers must use the ACD Special Processing Code AS when submitting claims for this CPT code.

8.11.7 Reimbursement Rates for ABS Services

8.11.7.1 Reimbursement of claims in accordance with the guidance in paragraph 8.11.6 will be established based on independent analyses of commercial and CMS ABA reimbursement rates. The national rates for ABA services will then be adjusted by geographic locality using the Medicare Geographic Practice Cost Indices (GPCIs).

8.11.7.2 ABA reimbursement rates will be updated at the same time as the annual CHAMPUS Maximum Allowable Charge (CMAC) Update, and will be effective May 1st. The rates will also be posted at http://www.health.mil/rates.

- The contractor shall update their reimbursement systems, once the rates are posted on the website, to reflect the annually updated rates in compliance with Chapter 1, Section 4, paragraph 2.4.

8.11.7.3 The contractor shall, for claims submitted beginning January 1, 2019, reimburse ABA services under the ACD in accordance with the reimbursement rates for the covered ACD CPT codes (rates are also listed at https://health.mil/Military-Health-Topics/Conditions-and-Treatments/Autism-Care-Demonstration

8.11.7.3.1 CPT code 97151.

8.11.7.3.1.1 Behavior Identification Assessment is authorized for only the authorized ABA supervisor (or as delegated to an assistant behavior analyst). For dates of services prior to August 1, 2021, CPT code 97151 is authorized for up to 16 units (four hours) of service code reimbursed for up to a total of $500.00 ($125/hour) at the initial assessment prior to rendering any other CPT code. For dates of services on or after August 1, 2021, CPT code 97151 is authorized for up to 32 units (eight hours) at $125/hour of services for the initial assessment only. Subsequent authorization periods shall be authorized for up to 24 units (six hours) of services at $125/hour. CPT code 97151 shall be conducted over no more than a 14 calendar-day period.

8.11.7.3.1.2 The contractor may authorize one additional unit of CPT code 97151 per outcome measure for providers that complete the Vineland, the SRS, the PSI/SIPA, when prior authorized.

8.11.7.3.2 CPT code 97153. Adaptive Behavior Treatment by Protocol. CPT code 97153 is a timed code reimbursed no lower than $31.25 per 15-minute increments ($125.00/ hour) for authorized ABA supervisors, $18.75 per 15-minute increment ($75.00/hour) for assistant behavior analysts, and $12.50 per 15-minute increment ($50.00/hour) for BTs.

8.11.7.3.3 CPT code 97155. Adaptive Behavior Treatment by Protocol Modification is rendered by an authorized ABA supervisor for treatment protocol modification with the beneficiary present. CPT code 97155 is reimbursed no lower than $31.25 per 15-minute increment ($125.00/hour) for the authorized ABA supervisor and $18.75 per 15-minute increment ($75.00/hour) for the assistant behavior analyst delegated this responsibility.

8.11.7.3.4 CPT code 97156. Family Adaptive Behavior Treatment Guidance. Authorized ABA supervisor (or as delegated to an assistant behavior analyst) treatment guidance to the parents/caregivers (with or without the beneficiary present) is reimbursed no lower than $31.25 per 15-minute increment ($125.00/hour) for the authorized ABA supervisor.

8.11.7.3.5 CPT code 97157 (authorized beginning August 1, 2021). Multiple-Family Group Adaptive Behavior Treatment Guidance. Authorized ABA supervisor treatment guidance in a group setting to the parents/caregivers (without the beneficiary present) is reimbursed at the geographically adjusted reimbursement methodology for CPT code 90853 (group psychotherapy) for each participant.

8.11.7.3.6 CPT code 97158 (authorized beginning August 1, 2021). Group Adaptive Behavior Treatment with Protocol Modification. Authorized ABA supervisor treatment guidance in a group setting to the beneficiaries is reimbursed at the geographically adjusted reimbursement methodology for CPT code 90853 (group psychotherapy) for each participant.

8.11.7.3.7 For CPT codes 99366 and99368 (authorized beginning August 1, 2021), see https://health.mil/. Reimbursement rates can be found using the search word "CMAC".

8.11.7.3.8 Concurrent billing is excluded for all ACD Category I CPT codes except when the family and the beneficiary are receiving separate services and the beneficiary is not present in the family session. Documentation must indicate two separate rendering providers and locations for the services.

- The contractor shall pay the higher rate and deny the other if CPT codes 97153 and 97155 are billed concurrently.

CPT CODES	97151	97153	97155	97156	97157	97158
97151	N/A					
97153	Y	N/A				
97155	N	N	N/A			
97156	Y	Y	Y	N/A		
97157	Y	Y	Y	N	N/A	
97158	Y	N	N	Y	Y	N/A

8.11.7.4 For BCBAs submitting claims for T1023 for services on or after May 1, 2019, the reimbursement rate shall be the geographically adjusted reimbursement methodology for the previous CPT code 96102 and updated with the CMS Medicare Economic Index (MEI) annually. The reimbursement for T1023 will be posted with the other ABA reimbursement rates at https://www.health.mil/Military-Health-Topics/Conditions-and-Treatments/Autism-Care-Demonstration. Reimbursement is limited to one unit per outcome measure until July 31, 2021. (PDDBI: [Parent and Teacher form]: if initial authorization, the contractor may authorize up to two units solely for the

purpose of the PDDBI at baseline and then at reauthorization. Vineland-3/SRS-2: one unit each per one year period). As of August 1, 2021, all outcome measures will no longer be reimbursed by T1023, meaning current authorizations will be effective until their expiration at which time, the subsequent treatment authorization will follow paragraph 8.11.6.2.1 (CPT code 97151- see this paragraph for details on reimbursement for the authorized outcome measures for new authorizations).

8.11.7.5 The balance billing provisions for non-participating providers as outlined in the TRM, Chapter 3, Section 1, paragraph 4.0 do not apply. ABA providers may not bill the beneficiary more than 100% of the rates posted at https://www.health.mil/rates.

8.11.7.6 Negotiated provider rates lower than those directed in this paragraph are not allowed.

8.11.7.7 Policies in this section must be adhered to or claims may be recouped.

8.11.8 Cost-Sharing

8.11.8.1 Effective January 1, 2018, all beneficiary cost-sharing, deductibles, and enrollment fees will be those applicable to the specific category of the TRICARE eligible beneficiary receiving services under this demonstration; e.g., TRICARE Prime, TRICARE Select; and TFL. For information on fees for Prime enrollees choosing to receive care under the Point of Service (POS) option, refer to 32 CFR 199.17 and TRM, Chapter 2, Section 1. There is no maximum Government payment or annual cap specifically for ABA services; TRICARE deductibles, enrollment fees, copayments, cost-shares, and the annual catastrophic cap protections implemented pursuant to 32 CFR 199 apply.

8.11.8.2 The contractor shall, for services rendered on or after January 1, 2019, apply only one copay for all ABA services rendered on the same day. Other (non-ABA) services rendered on the same day as ABA services will follow normal TRICARE cost-share/copayment rules.

8.11.8.3 The contractor shall, for CPT code 97151, apply one copayment for all assessment services rendered within a 14 calendar day period using this CPT code. If CPT code 97151 is billed on the same day as other ABA service, only one copay applies.

8.11.8.4 For Other Health Insurance (OHI), beneficiaries receiving ABA services are required to obtain a referral and prior authorization. ABA services under OHI will be reimbursed for only the covered services listed in this manual section.

9.0 ACD REQUIREMENTS

9.1 Utilization Management (UM)

9.1.1 The contractor shall implement UM tools, no later than August 1, 2021, to assist in guiding clinical decision making for all clinical necessity reviews that shall occur when approving all TPs; i.e., for the initial authorization and every six months thereafter.

9.1.2 The contractor's UM tools shall provide a set of evidence-based standards on TPs for beneficiaries diagnosed with ASD. UM tools/criteria are used to guide reviewers to consider the severity of behaviors in the context of patient-specific variables that help place a patient in the most appropriate level of care. Standardized decision paths provide UM reviewers with a common language that enables consistent, objective decision-making. UM addresses treatment needs of individuals

diagnosed with ASD who frequently receive treatments by providers from several different disciplines--such as ABA services, PT, OT, and SLP--that target the same core symptoms or functional deficits.

9.1.2.1 The basis of the UM tool shall integrate the comprehensive picture of treatment and progress to evaluate the extent to which skill domains are clinically necessary and appropriate.

9.1.2.2 The contractor shall select a UM tool that includes, at a minimum, the criteria to evaluate:

- Level of clinical support/need;
- TP programming;
- Dose response (intensity, frequency, duration);
- Progress towards improved symptom presentation, to include baseline functioning and cumulative periodic assessments (every six months) using, at a minimum, the identified outcome measures;
- Duration of services; and
- Other rendered/recommended services.

9.1.2.3 The contractor shall use the UM tool to determine clinical necessity determinations for all ABS CPT codes.

9.1.3 The contractor shall ensure that all clinical necessity reviews include an assessment of progress towards treatment goals. The TP and corresponding outcome measures must demonstrate progress towards symptom improvements.

9.1.4 The contractor shall, if no progress is made in the previous six months, engage the ABA provider to address the TP and goals prior to issuing another treatment authorization or transition services to more appropriate treatment (see paragraph 8.8 for discharge planning).

9.1.5 In general, ABA treatment hours should gradually decrease over time, as beneficiaries reach treatment goals and parents/caregivers gain skills and proficiency effectively managing behaviors related to the diagnosis of ASD.

9.1.6 The contractor shall employ a BCBA or a master's/doctoral level professional in a like-specialty to complete clinical necessity reviews.

- The contractor's UM person shall be different from the ASN.

9.1.7 The contractor shall submit, as part of the annual UM/Medical Management (MM) plan, a comprehensive UM plan that incorporates all services for the diagnosis of ASD to DHA. For plan submission requirements refer to DD Form 1423, CDRL located in Section J of the applicable contract.

9.2 Program Integrity (PI)

9.2.1 The contractor shall leverage existing Program Integrity actions in accordance with Chapter 13, unless otherwise noted in this section.

9.2.2 The contractor shall, in addition to the requirement set forth in Chapter 13, Section 1 have an ACD PI Subject Matter Expert (SME) knowledgeable about the ACD.

9.2.3 The contractor's PI unit shall take action in accordance with Chapter 13, developing for potential patient harm, fraud, and abuse issues.

9.3 Additional Contractor Responsibilities

9.3.1 The contractor shall develop an ACD-specific webpage within the existing TRICARE website requirement, that provides ACD information and resources, designed for use by families, beneficiaries (when appropriate), and providers to include, but not limited to:

- Online directory for ACD providers no later than January 1, 2022, including but not limited to ABA provider, parent-mediated programs, ASD diagnosing providers, respite care, SLP, OT, PT, etc. (the online ACD provider directory may be part of the contractor's main online provider directory);

- ACD Education and Resources link no later than October 1, 2021as identified in this policy updated on at least a semi-annual basis. Existing databases may be incorporated into the contractor platform;

- Link to the Contractor Provider Portals no later than January 1, 2022, accessible to all TRICARE authorized providers and ACD providers serving a beneficiary with a diagnosis of ASD including direct and private sector care that serves as a platform for providers to communicate directly with the contractor for: secure messaging; beneficiary referral and authorization timeline information; TP submissions, certification, and directory changes.

- Contact information or link for submitting beneficiary or family member/caregiver complaints no later than October 1, 2021.

9.3.2 The contractor shall, for beneficiaries without an ASN, forward to the "gaining" contractor all ACD related documents within 10 calendar days of being notified that a beneficiary is transferring to a location under the jurisdiction of another contractor.

9.3.3 The contractor shall designate an ACD complaint officer to receive and address beneficiary family member/caregiver complaints. Contact information shall be provided to all parents/caregivers of beneficiaries receiving services under this demonstration on the contractor ACD specific website.

9.3.4 The contractor shall develop a provider education training, to be implemented no later than January 1, 2022, 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.

9.3.4.1 The TOP and USFHP contractors may use other provider education strategies to achieve the requirement set forth in paragraph 9.3.4.

9.3.4.2 The contractor shall submit the ABA provider training curriculum for DHA review and approval per CDRL requirements prior to executing the training.

9.3.4.3 The contractor shall ensure compliance with paragraph 8.3.10 by retaining evidence of attendance/completion.

9.3.4.4 The contractor shall impose a 10% claims penalty for all rendered services during the non-compliant period for any ABA provider who is non-compliant with this requirement.

9.3.5 The contractor shall submit a notice of disciplinary action for any provider including, but not limited to, ABA providers to their respective certifying/licensing body, with appropriate documentation, after a failed attempt to resolve the matter with the provider. The contractor may submit such notice prior to attempting to resolve the matter with the provider in cases involving the safety of the beneficiary.

9.3.6 The contractor shall deny services and/or recoup claims of an authorized ABA supervisor who has any restriction on their certification imposed by the BACB, Behavioral Intervention Certification Council (BICC), or QABA, or any restriction on their state license or certification for those having a state license or certification.

9.3.7 The contractor shall recoup claims and/or deny services for session notes that describe the rendering of non-ABA services.

9.3.8 The contractor shall authorize all CPT code units in the six-month authorization and monitor to ensure TP recommendations (per week/month respectively; see paragraph 8.11.6.2) are maintained and not exceeded.

- The contractor shall deny claims containing units (hours) over the approved authorization and the MUEs set for each CPT Code.

9.3.9 The contractor shall report allegations of abuse to authorities responsible for child protective services, military and family advocacy programs, and to state and national license or certification boards as appropriate, and to the Director, DHA, or designee.

9.3.10 Outcome Measures Oversight

9.3.10.1 The contractor shall ensure completion of the Vineland, the SRS, PDDBI, PSI/SIPA (current edition) at baseline and every six months or year thereafter for each beneficiary participating in the ACD.

9.3.10.1.1 The non-clinical support person may assist in the administrative tasks of completing this requirement.

9.3.10.1.2 The contractor may utilize other sources for collection of these measures, such as a provider (TRICARE-authorized or otherwise) submitting the measures as part of their standard assessment process.

9.3.10.2 The contractor shall transition all beneficiaries participating in the ACD prior to April 1, 2021 to a one-year timeline at the next earliest interval. For example, if the beneficiary is in their seventh month of ABA services, the Vineland and the SRS shall be completed by the twelfth month (five months later) and prior to the issuing of the next authorization.

9.3.10.3 The contractor shall use the date of receipt of the specific measure to determine the next chronological interval (six months or one year) for outcome measures due dates.

9.3.10.4 The outcome measures timeline does not change when changing regions, provider, or beneficiary category. If the beneficiary or family elects to pause services from the ACD, ASN and/or ABA services for more than 180 calendar days, the timeline resets to collect outcome measures.

9.3.10.5 The contractor shall accept and report only complete and valid outcome measures.

9.3.10.6 The contractor shall accept valid measures for baseline data with dates up to one year prior to initiation of services.

9.3.10.7 The contractor shall terminate ASN services and not issue a subsequent ABA treatment authorizations for failure to complete any and all outcome measures.

9.3.10.8 The contractor shall transition to the new edition within one year of its release, should the outcome measure edition update.

9.3.11 Provider Networks

This paragraph applies only to the 50 U.S., District of Columbia, and U.S. territories. See paragraph 8.5 for TOP.

9.3.11.1 The contractor shall establish network contracting targets sufficient to support the ACD program IAW access standards and network expansion prescribed in Chapter 5, Section 1 and apply existing network requirements and access standards to providers under the ACD program.

9.3.11.2 The contractor shall ensure that the beneficiary shall begin ABA treatment services within 28 calendar days from the completed ABA assessment date.

9.3.11.3 The contractor shall certify all BTs within 10 business days of a complete application package that meets all requirements.

9.3.11.4 The contractor shall include the provider's work address, work fax number, work telephone number, and hours of operation in their directory.

9.3.11.5 The contractor shall include information regarding ages served, telehealth capabilities, and available session settings (in-home, clinic-based, both) in their directory.

9.3.11.6 The contractor shall engage in an active provider placement process, no later than August 1, 2021, to ensure access to care standards are met.

9.3.11.6.1 The contractor shall have up to 15 business days to complete the active provider placement process.

9.3.11.6.2 The contractor shall have a process that confirms when a beneficiary is referred to a new ABA provider, that the provider can provide an assessment (CPT code 97151) within 28 calendar days of the verified referral (this 28 day period includes the 15 business day provider placement), and that the provider will be able to provide the ABA services (CPT codes 97153, 97156, or 97157) within 28 calendar days of the completion of the assessment.

9.3.11.6.3 The contractor shall document that the provider was able to accept and see the beneficiary within access to care standards.

9.3.11.6.4 The contractor shall also document in the beneficiary's file when a family declines access to an available provider who can meet the access to care standards.

Note: MTF directed referrals or family requests for a specific provider do not ensure access to care standards. Therefore, these recommendations will be taken into consideration, but do not guarantee timely placement. The contractor is not required to comply with directed referrals for ABA providers if doing so will exceed access to care standards. Should the family specify a specific provider, access to care is also not guaranteed.

9.3.12 ABA Provider Steerage Model

The TOP and USFHP DPs contractors are exempt from paragraphs 9.3.11 through 9.3.11.3.

9.3.12.1 The contractor shall develop an ABA provider steerage model, to be implemented no later than January 1, 2022, for individual authorized ABA supervisors which shall take into account, at a minimum:

9.3.12.1.1 Compliance with access standards.

9.3.12.1.2 Include at least one other determinant into their ABA provider steerage model. Any additional determinants shall be submitted to DHA for approval prior to implementation. This additional determinant shall be an objective, verifiable measure that has a direct impact on beneficiaries or their families.

9.3.12.2 The contractor shall assign beneficiaries to ABA providers who rank highest in the steerage model when possible consistent with access to care standards.

9.3.12.3 The contractor shall list ABA providers who rank highest in the steerage model first in the online provider directories and shall give priority to those who rank highest when assigning patients to a provider.

9.3.13 The contractor shall complete and timely submit quarterly and annual Comprehensive Autism Care Reports. For reporting requirements, refer to DD Form 1423, CDRL, located in Section J of the applicable contract.

- The TOP contractor shall submit ad hoc reports in accordance with the TOP contract.

9.3.14 The contractor shall ensure all TRICARE Encounter Data (TED) requirements outlined in the TRICARE Systems Manual (TSM), Chapter 2 are met including appropriate use of Special Processing Code AS (Comprehensive ACD).

9.3.15 The contractor shall maintain one toll-free telephone number, specific to the ACD, to answer all provider and beneficiary questions. All ACD-specific customer service staff shall be knowledgeable of the most up to date ACD policy and provide consistently accurate information.

- The TOP, USFHP DPs, and TFL contractors shall use their existing telephone number for provide and beneficiary questions.

9.3.16 The authority for all aspects of the ACD, which is administered separate and apart from the general regulations and Manual sections governing the TRICARE Basic Program, and also separate and apart from ECHO, is defined per statute (10 United States Code (USC) 1092 as further implemented by 32 CFR 199.1(o)). The ACD is specifically implemented by Federal Register notice as required by 32 CFR 199.1(o) and DoD AI-102.

9.3.17 The contractor shall not, unless specifically identified in this Manual and if the contractor identifies a gap in the ACD policy, automatically default to normal TRICARE policy, but shall contact DHA for clarification.

10.0 EFFECTIVE DATE AND DURATION

Requirements for coverage under the ACD are effective as of July 25, 2014. The ACD is authorized through December 31, 2023.

11.0 DEFINITIONS

11.1 Adaptive Behavioral Services (ABS)

According to the American Medical Association (AMA) CPT coding guidance, ABS address deficient adaptive behaviors (e.g., instruction-following, verbal and nonverbal communication, imitation, play and leisure, social interactions, self-care, daily living, and personal safety skills) or maladaptive behaviors (e.g., repetitive and stereotypic behaviors, and behaviors that risk physical harm to the patient, others, and/or property).

11.2 Applied Behavior Analysis (ABA) Assessment

A developmentally appropriate assessment and reassessment tool must be used for formulating an individualized ABA TP and is conducted by an authorized ABA supervisor. For TRICARE purposes, an ABA assessment shall include data obtained from multiple methods to include direct observation, the measurement, and recording of behavior. A functional assessment that may include a functional behavior analysis may be required to address problematic behaviors. Data gathered from a parent/caregiver interview and parent report rating scales are also required. The ABA assessment will also include standardized outcome measures at appropriate intervals as noted above.

11.3 ABA Services

ABA methods designed to improve the functioning of a specific ASD target deficit in a core area affected by ASD such as social interaction, communication, or behavior. The ABA provider delivers ABA services to the beneficiary through direct administration of the ABA specialized interventions during one-on-one in-person (i.e., face to face) interactions with the beneficiary. ABA services may be comprehensive (addressing many treatment targets in multiple domains) or focused (addressing a

small number of treatment targets, such as specific problem behaviors and/or adaptive behaviors).

11.4 ABA Sole Provider Model

A service delivery model that includes only the use of the authorized ABA supervisor to implement a TP designed by the authorized ABA supervisor. The ABA sole provider delivery model is authorized in the Continental United States (CONUS), U.S. territories, and TOP.

11.5 ABA Tiered Delivery Model

A service delivery model that includes the use of supervised assistant behavior analysts and/or BTs, in addition to the authorized ABA supervisor, to implement a TP designed by the authorized ABA supervisor. Supervised assistant behavior analysts may assist the authorized ABA supervisor in clinical support to include the supervision of BTs and the provision of parent(s)/caregiver(s) treatment guidance. Tiered delivery models are only authorized in the CONUS and U.S territories.

11.6 ABA TP

11.6.1 A written document outlining the ABA service plan of care for the individual, including the expected outcomes of ASD symptoms. For TRICARE purposes, the ABA TP shall consist of an "initial ABA TP" based on the initial ABA assessment, and the "ABA TP Update" that is the revised and updated ABA TP based on periodic reassessments of beneficiary progress toward the objectives and goals.

11.6.2 Components of the ABA TP include: the identified behavior targets for improvement, the ABA specialized interventions to achieve improvement, and the short-term and long-term ABA TP objectives and goals that are defined below. The ABA TP shall also include a discharge plan.

11.7 ABA TP Goals

These are the broad spectrum, complex short-term and long-term desired outcomes of ABA services.

11.8 ABA TP Objectives

The short, simple, measurable steps that must be accomplished in order to reach the short-term and long-term goals of ABA services.

11.9 Assistant Behavior Analyst

The term "assistant behavior analyst" refers to supervised Licensed Assistant Behavior Analyst (LABA), Board Certified Assistant Behavior Analyst (BCaBA), and Qualified Autism Service Practitioner (QASP).

11.10 Authorized ABA Supervisor

An authorized ABA supervisor, whether or not currently supervising, is defined as a Licensed Behavior Analyst (LBA), BCBA, BCBA-Doctorate (BCBA-D), or a clinical psychologist practicing within the scope of their state licensure or state certification.

11.11 Autism Services Navigator (ASN)

The ASN collaborates and oversees 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. An ASN must hold a current, valid, unrestricted license which include: a Registered Nurse (RN) with CM experience, clinical psychologist, LCSW, or other licensed mental health professionals who possess a certification in CM. The ASN must have clinical experience in: pediatrics, behavioral health, and/or ASD; a healthcare environment; and proven care management experience. This definition specifically excludes both BCBAs and assistant behavior analysts.

11.12 Autism Spectrum Disorder (ASD)

For ACD eligibility, the covered diagnosis is ASD (F84.0) according to the DSM-5/Autistic Disorder according to the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). The ASD diagnosis must specify the level of support according to the DSM-5 criteria (Level 1 = mild, Level 2 = moderate, or Level 3 = severe).

11.13 ASD Diagnosing and Referring Providers

11.13.1 ASD diagnosing and referring providers include: TRICARE-authorized PCMs and specialized ASD diagnosing providers. TRICARE authorized PCMs for the purposes of the diagnosis and referral include: TRICARE authorized pediatric physicians, pediatric family medicine, and pediatric Nurse Practitioners (NPs). Authorized specialty ASD diagnosing providers include: TRICARE-authorized physicians board-certified or board-eligible in developmental-behavioral pediatrics, neurodevelopmental pediatrics, child neurology, child psychiatry; doctoral-level licensed clinical psychologists, or board certified Doctors Of Nursing Practice (DNP). For DNPs credentialed as developmental pediatric providers, dual American Nurses Credentialing Center (ANCC) board certifications are required as follows:

- Either a pediatric NP or a family NP; and
- Either (Family, or Child/Adolescent) Psychiatric Mental Health Nurse Practitioner (PMHNP) or a (Child/ Adolescent) Psychiatric and Mental Health Clinical Nurse Specialist (PMHCNS).

11.13.2 For DNPs credentialed as psychiatric and mental health providers, single ANCC board certification is required as follows: as either a (Family or Child/Adolescent) PMHNP or a PMHCNS.

11.13.3 Diagnoses and referrals from Physician Assistants (PAs) or other providers not having the above qualifications shall not be accepted.

11.14 Behavior Analysis

Behavior analysis is the scientific study of the principals of learning and behavior, specifically about how behavior affects, and is affected by, past and current environmental events in conjunction with biological variables. ABA is the application of those principles and research findings to bring about meaningful changes in socially important behaviors in everyday settings. ABA, by a licensed and/or certified behavior analyst, focuses on treating behavior difficulties by changing an individual's

environment (i.e., shaping behavior patterns through reinforcement and consequences). ABA is delivered optimally when family members/caregivers actively participate by consistently reinforcing the ABA interventions in the home setting in accordance with the prescribed TP developed by the behavior analyst.

11.15 Behavior Analyst Certification Board (BACB)

The BACB is a nonprofit 501(c)(3) corporation established to "protect consumers of behavior analysis services worldwide by systematically establishing, promoting, and disseminating professional standards." The BACB certification offers the BCBA for master's level and above behavior analysts, the BCaBA certification for bachelor's level assistant behavior analysts, and the RBT credential for BTs with a minimum of a high school education.

11.16 Behavior Intervention Plan

Behavior Intervention Plans must include an operational definition of the target behavior excesses and deficits, prevention and intervention strategies, schedules of reinforcement, and functional alternative responses. Behavior Intervention Plans shall be submitted along with any TP identifying a target behavior excess or deficit.

11.17 Behavior Technician (BT)

The term "behavior technician" refers to high-school graduate level paraprofessionals who deliver one-on-one ABA services to beneficiaries under the supervision of the authorized ABA supervisor, and includes RBTs, ABATs, and BCATs.

11.18 Behavioral Intervention Certification Council (BICC)

"The BICC was established in 2013 to promote the highest standards of treatment for individuals with ASD through the development, implementation, coordination, and evaluation of all aspects of the certification and certification renewal processes. BICC is an independent and autonomous governing body for the BCAT certification program, a certification for BTs."

11.19 Clinical Necessity

Clinical necessity refers to services that are clinically indicated and appropriate to address a beneficiary's diagnosed condition and not in excess of the beneficiary's needs. The services must be individualized, specific, and consistent with the confirmed diagnosis of the beneficiary.

11.20 Comprehensive Care Plan (CCP)

The CCP refers to a plan that is developed and maintained by the ASN. The CCP shall identify all care and services for the diagnosis of ASD, as well as, transition timelines to include, but not limited, to Permanent Change of Station (PCS) orders. The CCP will allow for a more consistent and beneficiary-centric approach to care.

11.21 Family/Caregiver

11.21.1 Family/Caregiver follows the definition for "immediate family" in 32 CFR 199.2(b): [t]he spouse, natural parent, child and sibling, adopted child and adoptive parent, stepparent, stepchild, grandparent, grandchild, stepbrother and stepsister, father-in-law, mother-in-law of the beneficiary, legal guardian as appropriate. For the purposes of the ACD, a "nanny" may be considered an eligible caregiver pending the following requirements are met:

- At least 18 years of age.
- Employed full-time by the family or an agency on behalf of the family (but must work full-time with the child).
- The nanny is documented in the Service family care plan. Documentation must be submitted to the contractor.
- Has medical Power of Attorney.
- The approved TP must identify the level of the nanny's participation to include specific goals.
- Caregiver (nanny) training cannot exceed parent training (CPT codes 97156 and 97157).

11.21.2 No other individual is considered "family" or "caregiver" under the ACD.

11.22 Functional Behavior Analysis

The process of identifying the variables that reliably predict and maintain problem behaviors that typically involve: identifying the problem behavior(s); developing hypotheses about the antecedents and consequences likely to trigger or support the problem behavior; and, performing an analysis of the function of the behavior by testing the hypotheses.

11.23 Medical Team Conferences

Medical team conferences are for the purpose of the treating providers to periodically meet to discuss the beneficiary and the overall program and progress towards goals. All CPT coding guidance and ACD requirements must be met for reimbursement of this code.

11.24 Parent-Mediated Programs

Parent-mediated interventions often focus on social reciprocity. In these programs, professionals train parents one-on-one or in group formats in home or community settings with methods that may include didactic instruction, discussion, modeling, coaching, or performance feedback. Once trained, parents implement all or part of the intervention(s) with their child.

11.25 Parenting Stress Index, Fourth Edition (PSI-4) or current edition (Abidin)

The PSI is a measure used for screening/triaging, and evaluating the parenting system and identifying issues that may lead to problems in the child's or parent's behavior. The PSI focuses on three

major domains of stress: child characteristics, parent characteristics, and situational/demographic life stress. Additionally, the PSI is useful in designing a TP, for setting priorities for intervention or for follow-up evaluation. The PSI is commonly administered in medical centers, outpatient therapy settings, and pediatric practices. The PSI is not intended to diagnose dysfunction in the parent-child relationship, or to be a screening tool of parental mental health problems. This outcome measure must be completed at baseline and every six months thereafter for beneficiaries ages 0 through 12 years only. Only the short form is required.

11.26 Pervasive Developmental Disorder Behavior Inventory (PDDBI) (Cohen, I.L. and Sudhalter, V. 2005 or current edition)

The PDDBI is an informant-based rating scale that is designed to assist in the assessment (for problem behaviors, social, language, and learning/memory skills) of children who have been diagnosed with ASD. The PDDBI provides age-standardized scores for parent and teacher ratings. Applicable for ages 2 through 18.5 years.

Note: Per guidance interpreted from the PDDBI manual and the publisher, the teacher form may be completed by the authorized ABA supervisor.

11.27 Qualified Applied Behavior Analysis (QABA) Certification Board

QABA "is an organization established in 2012 to meet para-professional credentialing needs identified by behavior analysts, ABA providers, insurance providers, government departments, and consumers of behavior analysis and behavior health services." QABA offers the QASP certification for bachelor's level assistant behavior analysts, and the ABAT certification for BTs with a minimum of a high school education or equivalent.

11.28 Qualified Health Care Professional (QHP)

A QHP is an individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.

11.29 Social Responsiveness Scale, Second Edition (SRS-2) or current edition (Constantino)

The SRS-2 identifies social impairment associated with ASD and quantifies its severity. Applicable for ages 2-1/2 through 99 years.

11.30 Stress Index for Parents of Adolescents (SIPA) or current edition (Sheras and Abidin)

The SIPA is a screening and diagnostic instrument that identifies areas of stress in parent-adolescent interactions, allowing examination of the relationship of parenting stress to adolescent characteristics, parent characteristics, the quality of the adolescent-parent interactions, and stressful life circumstances. Areas of parent-focused inspection include life restrictions, relationship with spouse/partner, social alienation, and incompetence/guilt. Areas of adolescent-focused inspection include moodiness/emotional liability, social isolation/withdrawal, delinquency/antisocial, and failure to achieve or persevere. The SIPA is the upward age extension of the PSI-Third edition (PSI-3). Applicable for ages 11-19 years.

11.31 Telehealth

See TPM, Chapter 7, Section 22.1 for all telehealth requirements.

11.32 Vineland Adaptive Behavior Scale, Third Edition (Vineland-3) or current edition (Sparrow, S.S. et.al)

The Vineland-3 is a valid and reliable measure of adaptive behavior for individuals diagnosed with intellectual disabilities and developmental disabilities (to include ASD). The Vineland-3 consists of an interview, a parental/caregiver, and teacher rater forms. Applicable for ages birth to 90 years.

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