All sole applied behavior analysis providers and Autism Corporate Services Providers in the TRICARE West Region must complete this training annually, per the guidelines outlined in TRICARE Operations Manual, Chapter 18, Section 4.

At the time of publication, Jan. 1, 2024, the information in this training is current.

TRICARE is a registered trademark of the Department of Defense Health Agency. All rights reserved.
CPT is a registered trademark of the American Medical Association. All rights reserved.

Table of Contents

(Section 1.0) Overview **1**

Welcome 1

Your TRICARE West Region Contractor 1

West Region Website 2

News/Did You Know… 2

Downloadable Quick Reference Aids and Other Materials 3

Key Contact Information 3

(Section 2.0) Learning Objectives **5**

(Section 3.0) Autism Care Demonstration Introduction **6**

Services Available to Beneficiaries With Autism Spectrum Disorder 6

TRICARE Basic Benefit 6

Extended Care Health Option 7

Other Services 7

Autism Care Demonstration 7

(Section 4.0) Benefits Under the Autism Care Demonstration **9**

Applied Behavior Analysis 9

Age Limitations 9

Services 9

Services Coordination With an Autism Services Navigator 10

What is an Autism Services Navigator? 10

Who's eligible for an Autism Services Navigator? 11

(Section 5.0) Autism Care Demonstration Providers **12**

Provider Types, Qualifications and Requirements 12

Applied Behavior Analysis Supervisors 12

Licensing and Certifications 12

Qualifications 13

Credentialing 13

Assistant Behavior Analysts 13

Licensing and Certifications 13

Qualifications 13

Credentialing 13

Behavior Technicians 14

Licensing and Certifications 14
Qualifications 14
Certification 14
Sole and Tiered Service Delivery Models 15
Provider Credentialing 15
Behavior Technician Certification Process 16
Documentation Required for Behavior Technician Certification 16
Basic Life Support/Cardiopulmonary Resuscitation Certification 16
Criminal History Background Checks 17
National Provider Identifier 17
Submitting Provider Rosters to Health Net Federal Services 17
(Section 6.0) Autism Care Demonstration Participation 18
Diagnosis 18
Additional Resources 18
Autism Care Demonstration Pre-Enrollment 19
Introduction of Autism Services Navigator Concept to Beneficiaries 19
TRICARE Plan Types 19
Required Enrollment Criteria for a Definitive Diagnosis 19
Autism Care Demonstration Post-Enrollment 21
(Section 7.0) Applied Behavior Analysis Referrals and Reauthorizations (Step 1) 22
Step 1: Referral to Receive Applied Behavior Analysis Services 22
Beneficiary Program Nomination to First Treatment Authorization Process 23
Referral Requirements 24
Diagnosing Providers 24
Required Information 24
Two-Year Referral Cycle Overview 25
Active Provider Placement Process 26
Provider Selection and Assignment 26
Applied Behavior Analysis Provider Steerage Model 27
(Section 7.1) Applied Behavior Analysis Referrals and Reauthorizations (Step 2) 29
Step 2: Completing the Initial Assessment 29
Access-to-Care Standards 29
Approval Letters 30

Second Opinions 30
General Requirements 30
Treatment Plan Requirements 31
Outcome Measures 34
Required Outcome Measure Assessments 34
Required Age-Based Outcome Measure 34
When are outcome measures required, and who can perform them? 35
Authorizations 36
Submission 37
(Section 7.2) Applied Behavior Analysis Referrals and Reauthorizations (Step 3) 39
Step 3: Requesting Treatment Authorization 39
Clinical Necessity Reviews 40
Clinical Necessity Review Process 41
Clinical Consultations 42
Clinical Necessity Review and Clinical Consultation Process Time Frames 43
Treatment Authorization Process 43
Compliant Request Packet Submission Example 43
Applied Behavior Analysis Service Settings 44
Exclusions 46
Goal-Related Exclusions 47
(Section 7.3) Applied Behavior Analysis Referrals and Reauthorizations (Step 4) 48
Step 4: Providing Applied Behavior Analysis Services 48
Access-to-Care Standards – Treatment 48
TRICARE-Approved Adaptive Behavior Services CPT Codes 49
97151 – Behavior Identification Assessment 49
97151 – Outcome Measures 49
97153 – Adaptive Behavior Treatment by Protocol 49
97155 – Adaptive Behavior Treatment by Protocol Modification 50
97156 – Family Adaptive Behavior Treatment Guidance 50
97157 – Multiple-Family Group Adaptive Behavior Treatment Guidance 50
97158 – Group Adaptive Behavior Treatment by Protocol Modification 51
99366 and 99368 – Medical Team Conference 51
Parent/Caregiver Training 51

Unit Modifications 51
Subsequent Authorizations 52
Referral Cycle Check 53
Two-Year Referral and Reauthorization of Treatment Process 54
Discharge Planning 55
Second Opinions on Discharge 55
(Section 8.0) Top Reasons for Delayed Treatment Authorizations 57
Pre-Clinical Necessity Review Screening: Missing or Inaccurate Information 57
Clinical Necessity Review: Missing or Insufficient Information 58
Goals: Missing or Insufficient Details 58
Community and School Locations: Insufficient Justification or Reason 58
Outcome Measures: Insufficient or Missing Details and/or Rationale 59
(Section 9.0) Reimbursement and Billing 60
Reimbursement 60
Electronic Funds Transfer 60
Cost-Sharing 60
Rates 61
Balance Billing 61
Hold Harmless 61
Understanding Units of Service 61
Weekly (CPT Code 97153) 61
Monthly (CPT Codes 97155, 97156, 97157, 97158) 61
Covering the Six-Month Authorization (CPT Codes 97151, 99366, 99368) 61
Medically Unlikely Edits 62
Concurrent Billing 62
Guidelines 62
What to Include in Claims 62
(Section 10.0) Progress Notes 64
General Information 64
Key Requirements 66
Common Mistakes With Progress Notes 66
(Section 11.0) Compliance and Audits 68
Medical Record Documentation and Billing Compliance 68

Audit Frequency (Existing and New Providers) 68
Existing Providers 69
New Providers 69
Audit Types 69
CPT Code 69
Administrative 70
Medical Documentation 70
Audit Common Issues 70
Audit Common Exclusions Identified 71
Audit Outcomes 72
Tips for Success 72
(Section 12.0) Autism Care Demonstration Resources 73
Applied Behavior Analysis Providers 73
www.tricare-west.com/go/ACD-provider 73
www.health.mil/autism 73
For Your TRICARE Patients 74
www.tricare-west.com/go/ACD 74
www.familysupport.hnfs.com 74
www.tricare.mil/autism 74
www.health.mil/autism 74
www.militaryonesource.mil 74
(Section 13.0) Contacting Health Net Federal Services 75
Who to Contact… 75
(Section 14.0) List of Abbreviations and Acronyms 77
Thank You 79

(Section 1.0) Overview

Welcome

Welcome to the *Annual Autism Care Demonstration Training for Applied Behavior Analysis Providers* in the TRICARE West Region. We encourage all applied behavior analysis (ABA) providers and staff to review this module; however, Health Net Federal Services, LLC (HNFS) assigns the training to the sole ABA provider and Autism Corporate Services Provider (ACSP) points of contact we have on file for providers as of January of each year. Once assigned, sole ABA providers and ACSPs have **90 days** to complete the training.

If you need assistance logging in to our online module at **https://hnfs.talentlms.com** for your practice to get credit for completing the training, please contact our Autism Care Demonstration (ACD) customer service line at **1-844-866-WEST** (follow the prompts) or email **ACDNetwork@hnfs.com**.

Providers required to complete the training who miss the 90-day deadline are subject to a 10% penalty that will be applied to all claims with authorized adaptive behavior services (ABS) Current Procedural Terminology (CPT®) codes beginning on day 91. This penalty will be remedied once the training has been completed; however, the penalty will remain in place for the days out of compliance.

Please visit **www.tricare-west.com/go/ACD-provider** and **www.health.mil/autism** for additional details on the ACD.

A reference guide for abbreviations and acronyms used throughout this course is provided in **(Section 14.0) List of Abbreviations and Acronyms**.

Your TRICARE West Region Contractor

TRICARE is available worldwide and managed regionally. There are two TRICARE regions in the United States: the TRICARE East Region (East Region) and the TRICARE West Region (West Region).

As the contractor in the West Region, HNFS administers the TRICARE program in Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa (except the Rock Island Arsenal area), Kansas, Minnesota, Missouri (except the St. Louis area), Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Texas (areas of western Texas only), Utah, Washington, and Wyoming.

Note: If you are a provider for the East Region, please visit the Humana Military website for the East Region-specific training module.

West Region Website

Questions? Refer to **www.tricare-west.com/go/ACD-provider** for provider-specific information and resources about:

- Treatment plans
- Billing and reimbursement
- Documentation
- Clinical necessity reviews
- Audits
- Frequently asked questions

…and more.

News/Did You Know…

Check your inbox for HNFS notifications about program changes and tips for claims and treatment plan submissions, provider requirements, best practices, and more. We email these notifications to the email address provided in network participation agreements and to those who've registered for our secure provider portal at **www.tricare-west.com**.

You also can visit our **Autism Care Demonstration: News Articles** page to view current and past articles.

Downloadable Quick Reference Aids and Other Materials

We offer quick reference aids and downloadable content at **www.tricare-west.com/go/ACD-provider**. Find printable resources on:

- Authorization codes and determination reasons
- Clinical necessity reviews
- Outcome measures
- Medical documentation requirements
- Treatment plan requirements

…and more.

Key Contact Information

Additional contact information is available in **(Section 13.0) Contacting Health Net Federal Services**.

Contact Method	Specifics	Information Available
ACD Customer Service Line	**1-844-WEST (9378)**, follow the prompts Monday through Friday 5 a.m.-9 p.m. PT **Note:** Provider locator services available 24/7 through **1-844-866-WEST (9378)**.	Dedicated ACD teams available to assist you with: • Eligibility • Benefits • Finding a provider • Authorizations and referrals • Claims • Moving • Access to care **…and more!**

Contact Method	Specifics	Information Available
Email	**CS_ABA@hnfs.com**	Email ACD-specific questions to our dedicated ACD customer service team.
Online	**www.tricare-west.com/go/ACD-provider**	• ACD-specific content • HNFS' network and ACD-specific provider directories • West Region local resources • Secure *Ask Us* email for claims (login required)

(Section 2.0) Learning Objectives

Upon successfully completing the *Annual Autism Care Demonstration Training for Applied Behavior Analysis Providers*, participants will:

- Be familiar with services available for autism spectrum disorder (ASD) treatment under the ACD.
- Know the different ABA provider types authorized to provide care under TRICARE's ACD and specific licensing and certification requirements.
- Understand the referral and treatment authorization process for ABA services under the ACD.
- Learn about reimbursement and billing best practices.
- Understand auditing requirements.
- Learn about key information to include in progress notes.
- Know where to locate more information on ACD requirements.

(Section 3.0) Autism Care Demonstration Introduction

Services Available to Beneficiaries With Autism Spectrum Disorder

TRICARE beneficiaries diagnosed with ASD have multiple clinical and non-clinical services available.

TRICARE Basic Benefit

Many services for managing and treating ASD are covered under the TRICARE basic benefit. These include but are not limited to:

- ASD diagnosis
- Medical team conferences with an interdisciplinary team of health care professionals (Refer to the information box below for more details.)
- Occupational therapy (OT), physical therapy (PT) and speech therapy (ST)
- Pharmacotherapies
- Psychotherapies and counseling
- Psychological testing
- Parent-mediated programs
- Speech services

ABA providers are not permitted to render services under the basic benefit unless separately credentialed for those specialties with a dual credential. This includes medical team conferences, which are only available to ABA providers under the ACD.

For more information about TRICARE-covered services, visit **www.tricare-west.com/go/ACD-provider** and **www.tricare.mil/coveredservices**.

Extended Care Health Option

The Extended Care Health Option (ECHO) is a supplemental benefit program that provides services and supplies beyond the basic TRICARE military health care program.

- **Active duty family members (ADFM).** ECHO is available to ADFMs who meet the qualifications of a specific physical, developmental and/or mental disability.
- **What the program provides.** The program provides beneficiaries with coordinated ECHO services (including respite) and supplies to reduce the disabling effects of the qualifying condition or disorder.
- **Learn more about ECHO.** To learn more about ECHO, visit our **Extended Care Health Option** page or **www.tricare.mil/echo**.

Patients who are family members of an active duty service member (ADSM) must register for ECHO to participate in the ACD. Registration deadlines for ECHO apply.

Other Services

Additional services available to support beneficiaries with ASD include:

- **Department of Defense (DOD).** Other sources within the DOD such as **Military OneSource**, **Exceptional Family Member Program** (EFMP), etc.
- **Government programs.** Other government programs such as the **Medicaid Waiver** program.
- **Academic/educational services.** Other academic and educational services such as an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) provided by the school district.

Not all services may be appropriate (clinically or otherwise) for all people, families or situations.

Autism Care Demonstration

TRICARE's ACD allows for clinically necessary and appropriate ABA services to be rendered to TRICARE-eligible beneficiaries diagnosed with ASD.

The overarching goal of the ACD 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.” (TRICARE Operations Manual [TOM], Chapter 18, Section 4)

Under the ACD, ABA providers are authorized to render only those ABA services targeting core ASD symptoms.

(Section 4.0) Benefits Under the Autism Care Demonstration

Applied Behavior Analysis

The ABA services authorized under the ACD depend on the patient's individual needs as determined by assessments and treatment progress.

Providers must have an approved authorization (with an authorization number) prior to rendering reimbursable ABA services. This includes assessments and treatment and applies to all qualifying **TRICARE plan types**, regardless of whether the beneficiary has other health insurance (OHI).

Age Limitations

There are no minimum or maximum age or duration limits, but authorization is based on clinical necessity.

Services

- Initial assessments and reassessments
- Development of a treatment plan to include specific goals and discharge planning
- One-on-one intensive ABA services
- Training of immediate family members on ABA principles and generalization of skills

- Program modifications based on progress within the treatment plan goals, outcome measures and parent/caregiver engagement

Services Coordination With an Autism Services Navigator

As of Oct. 1, 2021, TRICARE introduced Autism Services Navigators (ASN) to the ACD. Once a beneficiary who is new to the ACD has met enrollment criteria, HNFS assigns the beneficiary an ASN. As an ABA provider, you may be contacted by an ASN as part of the care coordination process.

What is an Autism Services Navigator?

ASNs oversee and/or collaborate with families, helping them navigate:

- ASD and comorbid diagnosis care coordination
- Coordination and facilitation of care
- Assessments throughout ACD care
- Promotion of individualized options and services

The ASN's role is that of a health care advocate; an ASN does not perform clinical necessity reviews of treatment plans or make TRICARE coverage determinations.

ASN responsibilities include but are not limited to:

- Developing and maintaining individual comprehensive care plans (CCP).

  Note: CCPs are separate from and do not replace the treatment plans developed by ABA providers.
- Coordinating medical and mental health care services with providers.

- Coordinating and participating in medical team conferences.

  Note: When approved, ABA providers can participate in medical team conferences; the ASN will coordinate the meeting.

- Helping beneficiaries new to the ACD with setting up medical appointments and coordinating care for those transitioning to a new TRICARE region (East, West, overseas) or moving within their current TRICARE region.
- Helping beneficiaries maximize their potential by engaging in care coordination for their ASD, as well as any comorbid disorders. This includes connecting families with local resources and support to help them effectively manage care required for short- and long-term needs.

ASNs do not perform clinical necessity reviews of ABA treatment plans or make TRICARE coverage determinations.

Who's eligible for an Autism Services Navigator?

All beneficiaries who have entered the ACD for the first time on or after Oct. 1, 2021, are considered new. Beneficiaries also are considered new if they paused or discontinued ABA services for more than 365 days.

Important!

- **Beneficiaries who are eligible for but decline an ASN are no longer eligible for the ACD.**
- **ABA services may be suspended if the beneficiary's initial or updated CCP is not completed within applicable timelines. Refer to www.tricare-west.com/go/ACD-provider > *Autism Services Navigators* to learn more.**

(Section 5.0) Autism Care Demonstration Providers

Provider Types, Qualifications and Requirements

Throughout the course of ABA treatment, TRICARE beneficiaries in the ACD may receive ABA services from one or more of the following provider types. **Note:** HNFS' **Autism Care Demonstration Provider Directory** can be used to find providers who can diagnose ASD and who can treat beneficiaries diagnosed with ASD.

Applied Behavior Analysis Supervisors

Licensing and Certifications

- Board Certified Behavior Analyst® (BCBA®)
- Board Certified Behavior Analyst – Doctoral® (BCBA-D®)
- Licensed behavior analyst (LBA)
- Clinical psychologist

Qualifications

TRICARE-authorized ABA supervisors must have:

- A master's degree or above in a qualifying field as defined by the state licensure/certification;
- An 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
- Certification from the Behavior Analyst Certification Board, Inc.® (BACB®) where such state-issued licensure or certification is not available.

Credentialing

ABA supervisors require credentialing by HNFS and must be approved prior to rendering services.

Assistant Behavior Analysts

Licensing and Certifications

- Board Certified Assistant Behavior Analyst® (BCaBA®)
- Qualified Autism Service Practitioner – Supervisor (QASP-S®)
- Licensed assistant behavior analyst (LABA)

Qualifications

Assistant behavior analysts must:

- Have a bachelor's degree or above in a qualifying field as defined by the state licensure/certification.
- Have a current:
    - Unrestricted state-issued license or state certification if in a state that offers state licensure or state certification; or
    - Certification from the BACB or the Qualified Applied Behavior Analysis Credentialing Board (QABA®).

      Note: Assistant behavior analysts who do not meet state licensure or certification requirements for the assistant behavior analyst role may be recognized by TRICARE as a behavior technician (BT) without having to obtain the BT certification, if allowed by state law.
- Receive supervision in compliance with their certification board (supervision is not billable).
- Work under the supervision of an authorized ABA supervisor.
- If supervising BTs, be in compliance with BT certification boards for supervisory activities (supervision is not billable).

Credentialing

Assistant behavior analysts require credentialing by HNFS and must be approved prior to rendering services.

Behavior Technicians

Licensing and Certifications

- Registered Behavior Technician® (RBT®)
- Applied Behavior Analysis Technician® (ABAT®)
- Board Certified Autism Technician (BCAT)
- State-certified BTs (where applicable)

Qualifications

BTs must:

- Have a current certification from:
  - BACB (RBTs),
  - QABA (ABATs),
  - Behavioral Intervention Certification Council (BICC [for BCATs]), or
  - State certification (where applicable) before applying for TRICARE-authorized provider status. Should a state licensure or state certification specify a particular BT certification type, that state designation must be followed.
- Receive ongoing supervision in compliance with the BT-specific certification board (supervision is not billable).

Certification

BTs require HNFS certification and approval prior to rendering services (the effective date is the later of their national or state board certification date or their contract-effective date). HNFS is required to certify BTs as TRICARE providers within 10 business days from the receipt of a complete application.

Sole and Tiered Service Delivery Models

Two service delivery models are authorized under the ACD for ABA services: sole delivery and tiered delivery. The service delivery model chosen is based on the individual needs of the beneficiary.

- In a **sole delivery** model, all ABA services performed under the ACD are rendered by authorized ABA supervisors with a master's degree or higher.
- In the **tiered delivery** model, the authorized ABA supervisor may have additional provider types render ABA services to the beneficiary:
  - Assistant behavior analysts
  - BTs

Under the tiered delivery model, the support team may render care, ***but the ABA supervisor is always responsible for the oversight and direction of care.***

Whether you are a sole ABA provider or part of an ACSP/ABA group, HNFS is proud to partner with you to bring ABA services to eligible beneficiaries in the West Region. It's important you understand the requirements for maintaining participation status to ensure continued care for your patients and reimbursement for authorized services rendered.

Outside of this training module, be sure to familiarize yourself with the:

- TOM, Chapter 18, Section 4
- Title 32, Code of Federal Regulations (CFR), Part 199, §§ **199.6** and **199.9**

Provider Credentialing

HNFS is required to conduct a comprehensive credentials review on each ABA provider to verify that the requirements listed in TOM, Chapter 18, Section 4 are met. To expedite the credentialing process, we ask that you include basic life support (BLS)/cardiopulmonary resuscitation (CPR) certificates and criminal history background checks (CHBC) for any new ABA supervisors or assistant behavior analysts submitted on the roster.

ABA provider types subject to credentialing include TRICARE-authorized:

- BCBAs
- BCBA-Ds
- LBAs
- BCaBAs
- QASP-Ss

It can take HNFS 45 to 60 days from the receipt of a complete packet to credential a network ABA provider (BCBA, BCBA-D, LBA, BCaBA, or QASP-S) based on the accuracy of the information provided. You can check for credentialing status updates using our online **Check Credentialing Status** tool.

Recredentialing occurs **every three years**.

Behavior Technician Certification Process

BTs are subject to a certification process to participate as an ACD provider. To become certified, ABA provider groups must include all required documentation for new BTs when sending updated rosters. This differs from the credentialing process where most supporting documentation is collected separately from the roster.

Documentation Required for Behavior Technician Certification

- Proof of certification from the appropriate agency (for example, certificate number, registration number).

  Note: ABA provider groups do not need to submit this. HNFS will verify via the applicable agency's website.

- Copies of current BLS/CPR certifications, which must include training on a dummy (100% web-based courses are not acceptable).
- Copies of CHBCs.
  - CHBCs must include current federal, state and county criminal and sex offender reports for all locations resided or worked in during the previous 10 years.
  - Groups must submit copies of the CHBC for all new BTs submitted in a roster during the certification process (or the recertification process for existing network BTs who do not have a CHBC on file).

Due to the 10-day requirement to complete BT certification, HNFS will only start the certification process once we have received all the required documentation.

Recertification occurs **every two years**.

Basic Life Support/Cardiopulmonary Resuscitation Certification

All ABA providers must complete BLS- or CPR-equivalent certification as demonstrated by completion of a 100% in-person course or a hybrid course including a web-based instruction component and live component for demonstrating skills on a dummy.

- **ABA supervisors** and **assistant behavior analysts** (or group credentialing point of contact) must submit copies of BLS/CPR certifications during the roster submission process for all new providers.
- **BTs** (or group credentialing point of contact) must submit copies of BLS/CPR certifications during the roster submission process for all new providers.

Once on file, HNFS will reach out 30 days prior to the expiration date for updated BLS/CPR certifications.

Providers also can submit updated BLS/CPR certifications to HNFS at **HNFS_ABARosters@hnfs.com**. Please specify the provider's name and National Provider Identifier (NPI).

Criminal History Background Checks

All ABA providers must submit copies of CHBCs.

- **ABA supervisors** and **assistant behavior analysts** (or group credentialing point of contact) must submit copies of CHBCs during the roster submission process for all new providers (or the recredentialing process for existing network providers who do not have a CHBC on file).
- **BTs** (or group credentialing point of contact) must submit copies of the CHBC for all new BTs submitted on a roster during the roster submission process (or the recertification process for existing network BTs who do not have a CHBC on file).
- **For all providers:** CHBCs must include current federal, state and county criminal and sex offender reports for all locations resided or worked in during the previous 10 years.

HNFS runs the background checks of all sole ABA providers.

National Provider Identifier

All ABA providers must have an NPI. Verify your NPI record is up to date by visiting the Centers for Medicare & Medicaid Services' (CMS) **National Plan & Provider Enumeration System (NPPES) NPI Registry** database.

Submitting Provider Rosters to Health Net Federal Services

HNFS offers a ***Network TRICARE Provider Roster*** template for provider groups to use when adding new providers who need to be credentialed or certified and to submit demographic updates.

We are unable to process incomplete rosters. When listing ABA providers on the roster, please be sure to follow the instructions included in the template. Refer to the "Degree Reference Tool" and "Taxonomy to Specialty" tabs to ensure you enter accurate information. You also can watch our ***Network TRICARE Provider Roster Tutorial*** for a visual walkthrough on filling out the roster template and tips for avoiding common mistakes.

- HNFS requires BLS/CPR certifications and CHBCs for all **newly added** ABA providers (ABA supervisors, assistant behavior analysts and BTs) submitted on the roster.
- For **all other** providers submitted on the roster, HNFS' credentialing team will request any needed supporting documentation during the credentialing process.

Submit ABA provider rosters to **HNFS_ABARosters@hnfs.com**.

- Allow HNFS up to 60 days for credentialing new providers joining the network and 10 days for certifying BTs.
- Allow up to 45 days for demographic updates.

(Section 6.0) Autism Care Demonstration Participation

TRICARE beneficiaries must meet specific qualifications to participate in the ACD. You can learn more about beneficiary eligibility requirements on our **Eligibility and Diagnostic Criteria** page.

As a reminder…

- Patients who are family members of an ADSM must register for ECHO to participate in the ACD. Registration deadlines apply.
- Beneficiaries who are eligible for but decline an ASN will no longer be eligible for the ACD.

Diagnosis

Diagnosis occurs under the TRICARE basic benefit. TRICARE beneficiaries nominated for the ACD must have their TRICARE-authorized ASD diagnosing and referring provider submit either a referral or diagnostic evaluation stating a diagnosis of ASD using *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5) criteria to initiate the process for enrolling in the ACD.

Additional Resources

- TRICARE defines ASD diagnosing providers in TOM, Chapter 18, Section 4.
- Visit our **Eligibility and Diagnostic Criteria** page for more information.

Autism Care Demonstration Pre-Enrollment

Once HNFS has started the pre-enrollment process, the beneficiary will be supported for up to 180 days by HNFS' Autism Services Coordinators (non-clinical coordinators experienced with ASD populations and the ACD) who can assist the beneficiary with completing all enrollment criteria.

An Autism Services Coordinator is different from an ASN. ASNs are not assigned until we have verified ACD enrollment criteria for those eligible to receive ASN services.

Introduction of Autism Services Navigator Concept to Beneficiaries

HNFS introduces the ASN concept during the pre-enrollment phase. This ensures beneficiaries enrolled in the ACD understand the requirements of the program, the role of the ASN, and the steps for getting care once enrolled.

During the pre-enrollment phase, the ASN screening process begins. During this initial screening, an ASN will:

- Make an introduction.
- Confirm contact information.
- Educate the beneficiary on the role of an ASN.

Note: The ASN who makes this initial contact may not be the same ASN assigned once the beneficiary is officially enrolled.

TRICARE Plan Types

The ACD is available to eligible individuals enrolled in qualifying **TRICARE plan types**. *ECHO registration is required for family members of ADSMs.*

Required Enrollment Criteria for a Definitive Diagnosis

HNFS must verify the following required elements were submitted by the TRICARE-authorized ASD diagnosing and referring provider:

- **A referral or diagnostic evaluation indicating an ASD diagnosis.** Eligible beneficiaries must have an ASD diagnosis by a TRICARE-authorized primary care manager (PCM) or specialized ASD diagnosing provider. HNFS is unable to accept a "provisional" diagnosis. The referral may or may not specify ABA services. If the original referral received by HNFS does not meet the criteria for ABA services but meets the criteria for the first component of a definitive diagnosis, we will request a referral for ABA services from the referring provider once enrollment is complete.

- **The date of the initial ASD diagnosis.** We require, at a minimum, the year of diagnosis but will request "month/day/year" from the referring provider if not included in other submitted documentation.
- **A completed *DSM-5 Diagnostic Checklist*.** The *DSM-5 Diagnostic Checklist* identifies the level of support required according to DSM-5 ASD criteria. Only TRICARE-authorized ASD diagnosing and referring providers are eligible to complete the checklist. ABA providers are not permitted to complete the form.

  Note: The provider who completes the checklist does not have to be the same provider who completed the original diagnosis.
- **Complete results, including scores, of an approved validated assessment tool (VAT).**
  - HNFS will collect the results of an approved VAT from the TRICARE-authorized ASD referring and diagnosing provider prior to enrollment.
  - The VAT results submission is a one-time requirement.
  - Any one of the following VATs meet this requirement:
    - 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) (also requires submission of diagnostic evaluation with documentation of diagnosing methods used to supplement the GARS-3 parent questionnaire)

      Note: If the beneficiary has not completed an ACD-approved VAT, the Autism Services Coordinator can direct the beneficiary on how to obtain a diagnostic evaluation under the TRICARE basic benefit. The beneficiary will continue to be supported for up to the 180 days while the VAT can be completed.
- **Registration or provisional registration in ECHO (for ADFMs).** ADFMs must be registered in ECHO to participate in the ACD. ADFMs not currently registered in ECHO will receive provisional registration for up to 90 days. During the 90 days, the beneficiary's Defense Enrollment Eligibility Reporting System (DEERS) record will reflect a "400" eligibility code (full or provisional ECHO status) indicating the ADFM can access the ECHO benefit and continue the process of enrolling in the ACD and initiating ABA services.
  - ADFMs who do not submit proof of EFMP enrollment (or a waiver, when eligible) within the 90 days will be disenrolled from ECHO and will no longer be eligible for ABA services.
  - The 400 code shown in DEERS is the same indicator for provisional and registered status.
  - HNFS will offer Autism Services Coordinators to assist beneficiaries and provide family support for those who lose eligibility for ABA services between the expiration of the 90-day provisional period and registration into ECHO. If ECHO registration has not been completed after 180 days, the beneficiary will no longer be eligible for the ACD.

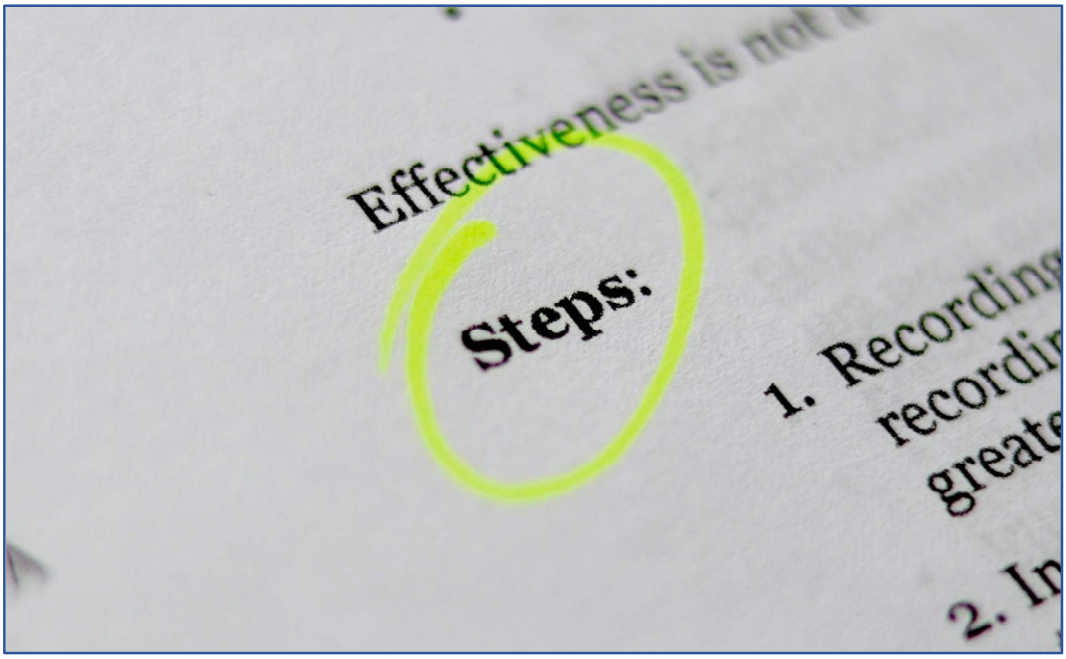
Autism Care Demonstration Post-Enrollment

Once HNFS has verified all definitive diagnosis and enrollment criteria have been met, the beneficiary will be officially enrolled into the ACD.

ACD enrollment will be closed to beneficiaries who are not able to complete all enrollment criteria within the 180 days of support from the Autism Services Coordinator.

Beneficiaries may reenter the enrollment process at any time and receive an additional 180 days of support.

(Section 7.0) Applied Behavior Analysis Referrals and Reauthorizations (Step 1)

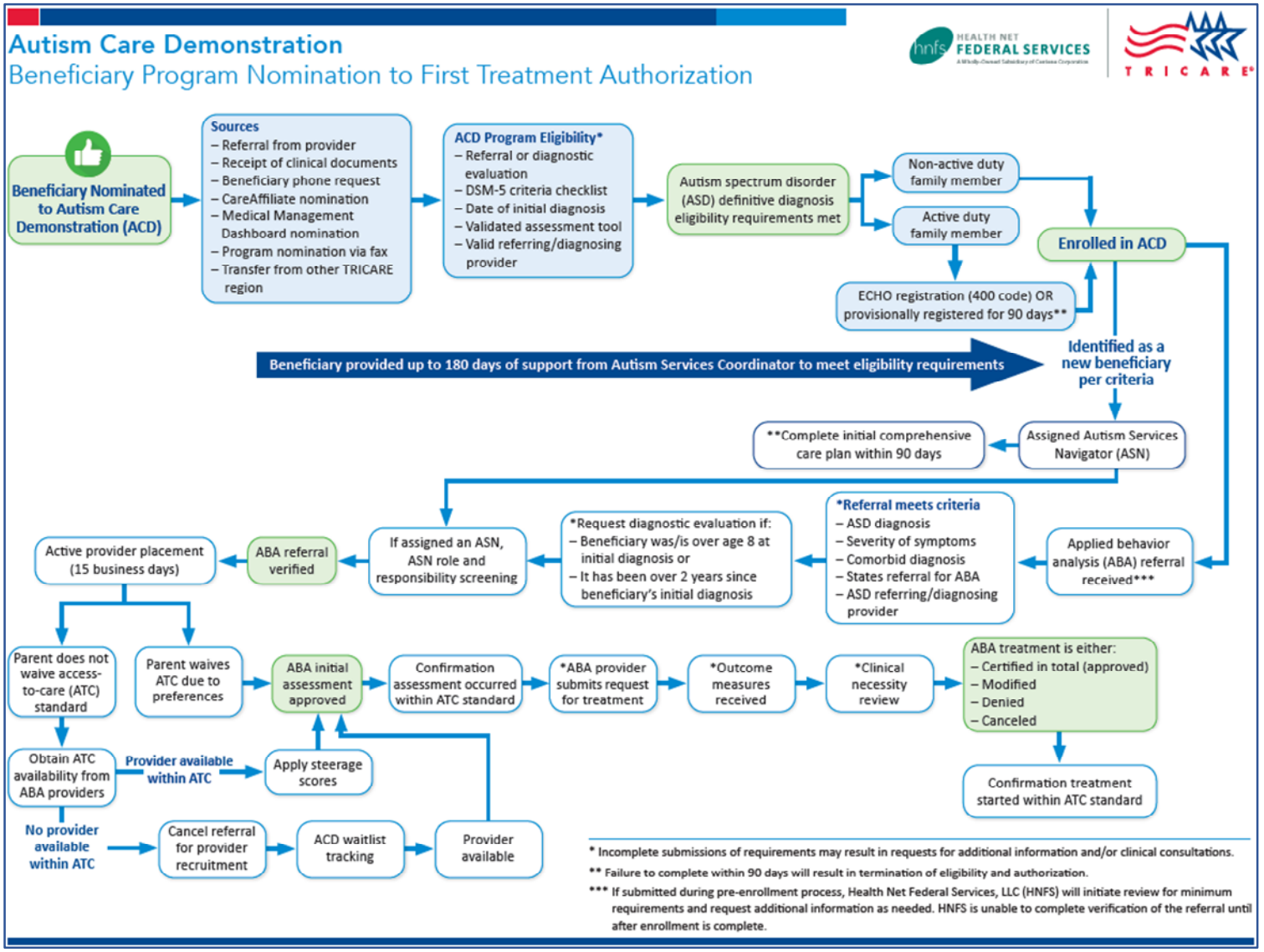


Understanding the steps required – from referral to initial authorizations and reauthorizations to discharge – will help you and your TRICARE patients stay on track.

Step 1: Referral to Receive Applied Behavior Analysis Services

If during the pre-enrollment process HNFS received a referral for ABA services, we must verify it meets all requirements for the ACD. If a referral was not received, we will request it from the referring physician. Refer to **"Beneficiary Program Nomination to First Treatment Authorization Process"** in this section for a visual depiction of the entire process.

Beneficiary Program Nomination to First Treatment Authorization Process



Referral Requirements

Diagnosing Providers

TRICARE-authorized PCMs or TRICARE-authorized specialized ASD diagnosing and referring providers must submit a referral to HNFS requesting ABA services that contains all required elements.

The following TRICARE-authorized provider types can diagnose and submit referrals:

PCMs

- Pediatricians
- Pediatric family medicine physicians
- Pediatric nurse practitioners

Specialized ASD Diagnosing and Referring Providers

- Physicians board-certified or board-eligible in:
  - Developmental-behavioral or neurodevelopmental pediatrics
  - Pediatric neurology or psychiatry
- Doctoral-level clinical psychologists
- Specific board-certified doctors of nursing practice* (DNP) who meet criteria

*DNPs credentialed as developmental pediatric providers require dual American Nurses Credentialing Center (ANCC) board certifications as either a pediatric nurse practitioner or a family nurse practitioner, and either a pediatric psychiatric mental health nurse practitioner (PMHNP) or a pediatric psychiatric and mental health clinical nurse specialist (PMHCNS). DNPs credentialed as psychiatric and mental health providers require a single ANCC board certification as either a PMHNP or PMHCNS.

Adult beneficiaries who are no longer within the age range of pediatric ASD diagnosing and referring providers must be referred by a doctoral-level clinical psychologist or non-pediatric DNP.

Review additional details about diagnosing and referring provider types in TOM, Chapter 18, Section 4.

Required Information

Referrals for ABA services must contain:

- ASD diagnosis
- Comorbid diagnosis (if applicable)
- Symptom severity level/level of support (1-mild, 2-moderate, 3-severe)
- Statement the beneficiary needs ABA services

HNFS has up to five business days to verify a referral meets all requirements per TRICARE policy and confirm the beneficiary meets all ACD eligibility requirements.

Note: If the beneficiary's initial ASD diagnosis occurred after age eight, or it has been two or more years since the original diagnosis and this is the first ABA services referral under TRICARE's ACD, HNFS will need a copy (if we do not already have one on file) of the TRICARE-authorized diagnosing provider's diagnostic evaluation with definitive diagnosis of ASD.

Two-Year Referral Cycle Overview

Referrals for ABA services under the ACD are valid for two years.

- Within each two-year referral cycle after the initial assessment, care is authorized in six-month periods.
- The two-year referral cycle is calculated every two chronological years from the date the verified referral was received by HNFS.

If HNFS has to request additional information from the referring provider to verify the referral, the chronological start date will be updated to the date the referral is complete and meets all requirements.

- Renewals for referrals may be submitted by the referring provider up to six months prior to the end of the two-year referral cycle. A verified referral received within the last six months of the two-year window will restart the two-year chronological timeline.
- At the two-year renewal, HNFS will need a new referral for ABA services that meets all requirements and a *DSM-5 Diagnostic Checklist* from the referring provider.

  Note: HNFS can accept a *DSM-5 Diagnostic Checklist* completed up to 180 days before the end of the referral due date.

Key things to remember about ABA services referrals:

- The two-year referral is valid for the beneficiary to receive an initial assessment and subsequent treatment authorizations until its expiration.
- If a beneficiary wants or needs to change providers, obtain a second opinion, move within the West Region, or move to the East Region or overseas, ***the referral is valid if it is still within the two-year time frame***.
- If HNFS receives a referral for ABA services before the last six months of the two-year referral cycle, ***we will cancel the request as a duplicate***.
- As an ABA provider, ***it is critical you do not ask military or civilian referring providers to submit referrals for ABA services every six months***. Beneficiaries who are due for a referral renewal (those who are in the last six months of the two-year time frame) should reach out to their referring provider and request a new referral.

Refer to **"Two-Year Referral and Reauthorization of Treatment Process"** in **(Section 7.3) Applied Behavior Analysis Referrals and Reauthorizations (Step 4)** for a visual depiction of the two-year referral process.

Active Provider Placement Process

Once the beneficiary has a verified referral on file, HNFS will begin the process of finding an ABA group or sole ABA provider who can render ABA services within access-to-care standards. We have 15 days from the date we verified the referral to complete the active provider placement process. We will notify beneficiaries once we've started.

Provider Selection and Assignment

HNFS' ACD active provider placement process involves authorizing care based on the following:

1. Does the provider currently meet TRICARE's access-to-care standards for initial assessments and treatment?
2. If more than one provider meets the first criteria, then which provider ranks highest in the steerage model (refer to the **"Applied Behavior Analysis Provider Steerage Model"** section below for more information)?

Or, if a parent/caregiver prefers a specific provider and chooses to waive access-to-care standards (must confirm this waiver directly with HNFS), we will authorize care to that provider.

When assigning providers, HNFS:

1. Contacts ABA providers to confirm availability for the initial assessment and treatment.
2. Attempts contact with the beneficiary and/or the parent/caregiver to discuss provider preferences and whether HNFS can meet them, but, ultimately, we will select a provider who can meet access-to-care standards.
3. Authorizes the initial assessment to an ABA provider group. This assessment must be completed within 28 days, with day one being the date HNFS verified the referral. HNFS will update the start date of the approved initial assessment with the date of the verified referral to ensure ABA providers can independently calculate the 28 days to initiate the assessment process.
4. May suggest starting parent/caregiver training ahead of direct services for families with preferred appointment times or locations (for example, afternoons at a center base). During this time, the ABA provider can support the family under approved parent/caregiver training CPT codes to target initial ABA principles and implementation until the beneficiary is receiving their full hours at their preferred times and locations.

Directed referrals (referrals received with a named provider) and parent/caregiver preferences will be taken into account during the active provider placement process, but, ultimately, HNFS is required to select providers who can meet the access-to-care standards unless waived by the parent/caregiver. This includes parent/caregiver preferences for location of services (center/clinic vs. home), time of day (morning, afternoon, evening, weekends) and specific providers or attributes.

Note: This process only applies to the initial assessment. HNFS does not apply active provider placement criteria when continuity of care has been established and providers are submitting initial or recurring treatment authorization requests.

Applied Behavior Analysis Provider Steerage Model

HNFS uses a steerage model for network ABA providers participating in the ACD. A steerage model determines a provider's ranking in the network based on their performance against a set of predetermined metrics. The ACD steerage model ranks ABA providers according to access-to-care standards and other quality measures that positively impact TRICARE beneficiaries.

HNFS' steerage model ranks providers using three quality measures:

- **Measure one** is tied to the provider's performance compared with TRICARE's access-to-care standards for initial assessments (achieved when service delivery occurs within 28 days of the verified referral).
- **Measure two** is tied to the provider's performance compared with TRICARE's access-to-care standards for treatment (achieved when the last date of service of the assessment [CPT code 97151] in the 14-day window to the first day of adaptive behavior treatment [CPT codes 97153, 97155, 97156, 97157, 97158] is 28 days or less).
- **Measure three** is tied to the average number of days from each treatment authorization start date ("service from date" on authorization) to the first parent/caregiver training session (CPT codes 97156 and 97157).

Providers with high quality ratings, as determined by performance against these three measures, receive priority placement in the Network Provider Directory and referral assignment preference after all access-to-care standards have been met.

Beneficiary and parent/caregiver preferences that impact access-to-care standards are excluded from these calculations and do not affect a provider's performance rating.

(Section 7.1) Applied Behavior Analysis Referrals and Reauthorizations (Step 2)

Step 2: Completing the Initial Assessment

Once the referral is authorized for an initial assessment, ABA providers will be authorized to start the initial assessment.

TRICARE has access-to-care standards specific to the ACD. **Your understanding of these standards helps you not only meet guidelines for TRICARE beneficiaries but improves your steerage model scores for future referrals.**

Access-to-Care Standards

The first date of service of the assessment (CPT code 97151) MUST be **within 28 calendar days from the date HNFS verified the referral**. Pre-authorization of the initial assessment is required.

- As HNFS has up to 15 business days to complete active provider placement, it's important for ABA providers to understand **those 15 days are included in the 28-day access-to-care standard** for starting the assessment.
- We will confirm if the access-to-care standard was met for the initial assessment or obtain rationale if not met. ABA providers are expected to respond to requests for information regarding the confirmation of meeting the access-to-care standards.
- The CPT code 97151 assessment must begin once the authorization has been approved within the 28-day TRICARE access-to-care standard and be completed within the 14-calendar day allowance from the first date of service. Initial assessment authorizations are approved for 45 days to facilitate meeting access-to-care standards and the 14-calendar day window. Please contact HNFS as soon as possible if you anticipate a delay in your ability to start the initial assessment within access-to-care standards.

- If a parent/caregiver chooses to waive access-to-care standards, HNFS must be contacted by the beneficiary or provider to waive the standard. Providers must respond if we request additional information about an access-to-care waiver. If you need to extend the initial assessment beyond the 45-day period, you must contact HNFS and provide rationale for the extension. A new referral will not be required.

Approval Letters

Providers and beneficiaries can view a copy of initial assessment determination letters at **www.tricare-west.com** (login required).

- The letter contains contact information for the beneficiary and ABA provider.
- Providers are expected to contact beneficiaries to schedule the initial session within three days.
- If you are unable to connect with the beneficiary within one week, please contact our **ACD customer service line** for assistance.

Second Opinions

- Beneficiaries or the family may request a second initial assessment from a different ABA provider to obtain another clinical recommendation or plan of care.
- Second opinion assessments follow the same referral, access-to-care, treatment plan, outcome measure, and process requirements as an initial assessment. A new referral is not required for second opinions if within the two-year time frame.
- The second opinion assessment can be completed by a different ABA provider, but only one ABA provider may be authorized to provide treatment at a time.

General Requirements

Initial assessments include direct service with the beneficiary and can include additional indirect methods that may be necessary to complete the treatment plan and unit recommendations.

The assessment must include:

- Direct observation, measurement and recording of beneficiary behavior.
- Background information that clearly demonstrates the beneficiary's condition, diagnoses, family history, and how long the beneficiary has been receiving ABA services.
- Functional behavior assessment.
- Data from parent/caregiver interview and parent/caregiver report rating scales.
- Treatment plan that meets all TOM, Chapter 18, Section 4 requirements.
- Results of the Pervasive Developmental Disorder Behavior Inventory (PDDBI) Parent Form. For more information on the PDDBI, visit our **Outcome Measures** page.

Treatment Plan Requirements

DHA outlines very specific instructions for ACD treatment plans. Each section within the treatment plan must meet detailed requirements. Please review TOM, Chapter 18, Section 4 and HNFS' ***Treatment Plan Requirements*** guide to ensure your ability to develop and submit a compliant treatment plan.

Treatment plans must include the following components:

- **Identifying information.**
  - Full name of beneficiary (must not be a nickname)
  - Date of birth (in MM/DD/YYYY format)
  - Date initial ABA assessment completed
  - Date initial ABA treatment plan completed
  - DOD Benefits Number (DBN) or sponsor Social Security number (SSN)
  - Name of ASD diagnosing and referring provider
- **Referral reason.**
  - TRICARE-authorized ASD diagnosing and referring provider's diagnosis of the patient's ASD
  - ASD criteria as defined in the DSM-5
  - Symptom severity and level of support
- **Background information.**

  Information that clearly details the beneficiary's:
  - Condition
  - Diagnoses/medical comorbidities, including statement of their absence from treatment (if applicable)
  - Medications, including over-the-counter medicine or, when applicable, a statement declaring no medicine use
  - Family history (history of diagnosis, family arrangement, factors related to treatment, etc.)
  - School enrollment status and number of hours enrolled in school (for example, Special Day Class [SDC] classroom at elementary school, Monday-Friday, 8 a.m.-12:30 p.m., etc.)
  - The number of hours (weekly or monthly) of other support services (if applicable), such as OT, PT or ST
  - Current age and the year of initial ASD diagnosis
  - Length of time the patient has been receiving ABA services (that is, total length of time – in years and months – receiving ABA treatment from all current and former ABA providers)
- **Summary of assessment activities.**
  - Include an objectively measurable list of behavioral deficits/excesses that create barriers to the beneficiary functioning in all domains applicable/related to core ASD symptoms (language development, social communication, clinical adaptive behavior skills)
  - Include assessment tools used to establish areas of treatment and treatment goals

- Identify if the patient can actively participate in treatment
- Identify whether the patient needs a behavior intervention plan for targeted behavior excesses and deficits
- Include the PDDBI Parent Form Domain/Composite Score Summary Table

- **Treatment plan goals.**
  - May include long-term goals and short-term objectives, such as the intermediary steps to meet long-term goals
  - Clinically necessary and appropriate goals must be:
    - Specific to the beneficiary and relevant to the family
    - Measurable in a specific time frame
    - Attainable in relation to the beneficiary's prognosis and developmental status
    - Directly related to core ASD symptoms (clearly defined, measurable targets relevant to the DSM-5)
  - Must have description or list of planned treatment strategies and techniques
  - Must identify the objective measure of progress that will be used for each goal specified
  - Must address core ASD symptoms only; cannot address daily living skills acquisition, educational or vocational activities or address related symptoms or goals better served by other specialties (for example, PT, OT, ST)

    Note: Refer to TOM, Chapter 18, Section 4 for additional exclusions.

- **Discharge planning.**

  Discharge plans must:
  - Provide specific and detailed goals (For example, do not use statements such as "when all treatment goals are met.")
  - Use statements that detail achievable, realistic treatment milestones; the ABA provider should include goals that will help prepare a patient's parent/caregiver for teaching ABA skills in the home
  - Individualize discharge criteria to the beneficiary, such as:
    - Specific behaviors keeping a patient from effectively interacting with others in the community
    - Communication and social skills that will help the patient interact with family and others in the community
    - How the patient will continue to respond to treatment based on symptom impacts noted so far
    - A parent's or caregiver's ability to incorporate strategies for supporting and maintaining ABA skills
    - A description of how ABA services will be lessened (for example, by recommended units or going from tiered to sole provider to parent/caregiver training program, etc.)

    - Referrals to non-ABA providers for patients with co-existing non-ASD–related medical conditions

- **Recommendations and units.**
    - Recommended units align with best practices and refer to the amount of eligible CPT code units necessary to achieve desired treatment outcomes based on clinical necessity
    - Requests for authorization should reflect the number of units recommended for the treatment of a particular beneficiary and their family
    - Recommended services/units must be based on a combination of the symptom domains and level of support required (per DSM-5 criteria), outcome measure scores (for treatment plan updates), availability of the patient, and whether the patient can participate actively in ABA services

  ABA providers must document:

    - Number of hours (submitted as units) of ABA services via each CPT code
    - Location of the services for each CPT code
    - Standardized hours (as units) for the reassessment period (CPT code 97151) – 24 units will be authorized for treatment for the reassessment
    - Weekly direct hours (CPT code 97153)
    - Monthly hours (as units) for program modification (CPT code 97155); one direct visit per month must be conducted by the authorized ABA supervisor; remaining visits in a month can be delegated as clinically appropriate to the assistant behavior analyst, if applicable
    - Monthly hours (as units) for parent/caregiver CPT codes 97156 and 97157
    - Parent/caregiver participation is required, and reauthorization is contingent on involvement, unless contraindicated; ABA providers are expected to document barriers to parent/caregiver training and work toward resolution
- **Signatures.**
    - Must contain authorized ABA supervisor signature
    - Must contain parent/caregiver signature

These additional requirements impact treatment plan approval:

- **Eligibility.** HNFS will confirm that TRICARE beneficiary eligibility requirements have been met and that ACD eligibility requirements have been met.
- **Referral time frame.** HNFS will confirm if a referral is within the two-year chronological time frame.
- **Outcome measures.** All applicable outcome measures must be submitted to HNFS before we can authorize treatment.
- **Clinical necessity review.** HNFS' qualified clinical necessity reviewers (BCBAs, BCBA-Ds) will complete a clinical necessity review on every treatment plan prior to a coverage determination.
- **Individualized Education Program.** The treatment plan must include a copy of the IEP, if applicable. Refer to TOM, Chapter 18, Section 4 for details.

- **Comprehensive care plan.** For beneficiaries eligible for an ASN, HNFS will verify a CCP is in place and that the CCP has been updated in the past six months. Beneficiaries work with their assigned ASNs to develop individualized CCPs within 90 days of treatment authorization. The CCP is then updated every six months in line with six- month treatment authorization renewals.

  As providers, you offer invaluable assistance helping parents/caregivers understand the CCP requirement and TRICARE-required submission due dates. When a CCP isn't submitted on time, HNFS must terminate the remaining authorized days on the corresponding active ABA authorization. This creates potential for delays or gaps in care, which may negatively impact the beneficiary, their family and any ABA providers working with the beneficiary.

- **Provider status.** To continue participating in the ACD, providers must remain compliant with ACD program requirements. To review provider requirements, please refer to TOM, Chapter 18, Section 4 and **www.tricare-west.com/go/ACD-provider**.

Outcome Measures

The ongoing, consistent execution of outcome measures plays an important role in treatment plan development. Outcome measures can help the ABA provider evaluate the efficacy of ABA and other interventions the beneficiary is receiving based on the beneficiary's improvement or regression. Visit our **Outcome Measures** page for more information and printable provider-specific guides and materials. **Note:** HNFS will not request protocols, questions or other assessment materials.

HNFS cannot complete a benefit review for coverage until we have received scores from all required outcome measures.

Required Outcome Measure Assessments

Under the ACD, TRICARE requires the following age-based outcome measures for beneficiaries:

- **PDDBI** – Ages 2 years to 18.5 years (can accept as early as 1.5 years)
- **Vineland Adaptive Behavior Scales**, Third Edition (Vineland-3) – Ages 0 years to 90 years
- **Social Responsiveness Scale**, Second Edition (SRS-2) – Ages 2.5 years to 99 years

Required Age-Based Outcome Measure

TRICARE requires an age-based outcome measure that evaluates parent stress – either the Parenting Stress Index, Fourth Edition Short Form (PSI-4-SF) or Stress Index for Parents of Adolescents (SIPA).[1] However, the age-based outcome measure is not used for developing treatment plans or evaluating patient improvements.

- **PSI-4-SF** – Ages 0 years to 12 years and 11 months
- **SIPA** – Ages 11 years to 19 years and 11 months

[1] Research has shown that parents' stress levels can impact their child and their child's environment, which in turn may affect their child's symptoms. The PSI-4-SF and SIPA are standardized, reliable measures of stress and family dynamics that help to identify where additional support resources may benefit both the family and the beneficiary.

Important!

The PSI-4-SF and SIPA have overlapping age ranges. At the time of authorization/ reauthorization:

- **For beneficiaries aged 11 years through 12 years and 11 months, either the PSI-4-SF or SIPA will be accepted.**
- **For beneficiaries older than 12 years and 11 months, the SIPA will be accepted.**

When are outcome measures required, and who can perform them?

Please review the following table detailing when outcome measures are required.

Note: Baseline is before HNFS first completes a benefit review for coverage. The renewal time frame of every six months and every year is measured from the date HNFS received the specific outcome measure. HNFS cannot accept outcome measure renewals if completed more than 90 days before the due date.

Required Outcome Measures

Outcome Measure	Baseline	Every 6 Months	Every Year	Performed/ Administered By
PDDBI Parent	Yes	Yes	N/A	Treating ABA supervisor (or delegated to an assistant behavior analyst)
PDDBI Teacher	No	Yes	N/A	Treating ABA supervisor (cannot be delegated)
Vineland-3	Yes	N/A	Yes	When authorized by HNFS: ABA providers (BCBA, BCBA-D, LBA, clinical psychologist) who can administer the Vineland-3, SRS-2 and PSI-4-SF/SIPA **OR** TRICARE-authorized ASD diagnosing and referring providers
SRS-2	Yes	N/A	Yes	When authorized by HNFS: ABA providers (BCBA, BCBA-D, LBA, clinical psychologist) who can administer the Vineland-3, SRS-2 and PSI-4-SF/SIPA **OR** TRICARE-authorized ASD diagnosing and referring providers

Additional Outcome Measure Requirements

Outcome Measure	Baseline	Every 6 Months	Every Year	Performed/ Administered By
PSI-4-SF	Yes	Yes	N/A	When authorized by HNFS: ABA providers (BCBA, BCBA-D, LBA, clinical psychologist) who can administer the Vineland-3, SRS-2 and PSI-4-SF/SIPA **OR** TRICARE-authorized ASD diagnosing and referring providers
SIPA	Yes	Yes	N/A	When authorized by HNFS: ABA providers (BCBA, BCBA-D, LBA, clinical psychologist) who can administer the Vineland-3, SRS-2 and PSI-4-SF/SIPA **OR** TRICARE-authorized ASD diagnosing and referring providers

For beneficiaries new to the ACD and in the pre-enrollment process, we can accept the completion of the Vineland-3, SRS-2 and PSI-4-SF/ SIPA up to one year before the start of ABA services.

Important!

Outcome measure renewals must be performed within 90 days of their due date. If HNFS receives outcome measure renewal results more than 90 days from their due date, they will be canceled, and the outcome measure will need to be repeated within the prescribed time frame.

Additional compensation for repeated outcome measures will not be approved.

Authorizations

HNFS can authorize outcome measures directly to ABA providers without a referral from the ASD diagnosing and referring provider. While the treating ABA provider is required to administer the PDDBI, HNFS may proactively authorize existing beneficiaries to our preferred network of ABA providers who can complete the Vineland-3, SRS-2 **and** PSI-4-SF/SIPA to meet access-to-care standards.

This means:

- For the Vineland-3, SRS-2 and PSI-4-SF/SIPA, a beneficiary may be authorized to see a different provider who is not the beneficiary's treating ABA provider.
- ABA providers may need to wait until all applicable outcome measures have been completed before we can begin the clinical necessity review process to determine coverage and authorize services.
- Outcome measure authorizations for the Vineland-3, SRS-2 and PSI-4-SF/SIPA will only be issued to one provider.

- HNFS will not authorize multiple providers for the same outcome measure and will not divide the Vineland-3, SRS-2 and PSI-4-SF/SIPA among multiple providers.

HNFS issues a separate authorization for the Vineland-3, SRS-2 and PSI-4-SF/SIPA outcome measures. We will NOT include units for these on the same authorization as the initial assessment or treatment authorization. This is to prevent overlap between the reassessment/PDDBI units and the outcome measure units, as both are under CPT code 97151. When submitting claim forms for outcome measure units, providers are instructed to include modifier 99.

Keep in mind:

- Treating ABA providers who can and prefer to complete all ABA outcome measures (PDDBI, Vineland-3, SRS-2, and PSI-4-SF/SIPA) for their existing TRICARE patients can request this through the reauthorization treatment plan.
  - Authorization requests submitted outside of a treatment plan update will be canceled.
  - If HNFS has already authorized the beneficiary to another ABA provider for the Vineland-3, SRS-2 and PSI-4-SF/SIPA, the treating ABA provider must wait until the next reassessment period to submit the treatment plan update.
- Treating ABA providers who do not have the ability or expertise to render the Vineland-3, SRS-2 and PSI-4-SF/SIPA can defer to HNFS to authorize these outcome measures to another ABA provider.
- Treating ABA providers should consider how a respondent's answers – or variations across a respondent's answers – may have influenced outcome measures when the ABA supervisor observes changes in scores indicating lack of progress. ABA supervisors are encouraged to ask respondents for additional details to ensure large variances in scores are not the result of inconsistent responses. This includes large score discrepancies between the PDDBI Parent and Teacher Forms, which should be addressed in treatment planning.

Submission

Outcome measure results must include the full publisher print report or hand-scored protocol and summary score sheet(s). Also, the results must include the name of the person who answered the questions in the outcome measures (name of respondent) and the person's relationship to the beneficiary. Requests for authorization will not be processed without these data points.

As previously noted, HNFS will not request protocols, questions or other assessment materials.

- Outcome measure results embedded in treatment plans or other clinical documents will not meet submission requirements.
- We offer outcome measure-specific printable fact sheets that outline required scores for each outcome measure. Refer to our **Outcome Measures** page for more information.

ABA providers and civilian specialized ASD diagnosing providers can attach a copy of the outcome measure results through our online authorization submission tool, **CareAffiliate** (login required). Use the *P175 – ACD Outcome Measure Authorization and Submission* request type.

Beneficiaries and military hospitals or clinics can submit outcome measures to the dedicated ACD fax line at **1-877-910-0945**.

(Section 7.2) Applied Behavior Analysis Referrals and Reauthorizations (Step 3)

Step 3: Requesting Treatment Authorization

Now that the initial assessment process is complete, ABA providers can submit their treatment authorization request electronically to HNFS using the online submission tools at **www.tricare-west.com**.

It's important to submit a complete and accurate treatment authorization request, as HNFS will verify the following requirements are in place before sending for clinical necessity review:

- TRICARE eligibility
- ACD eligibility
- Treatment plan with parent/caregiver goals and engagement
- PDDBI Parent Form scores
- Outcome measures (required before HNFS can authorize treatment)
- IEP, when applicable

ABA providers may not be reimbursed for any services rendered prior to HNFS authorizing ABA services.

Clinical Necessity Reviews

HNFS is required to perform clinical necessity reviews on all treatment plans before making coverage determinations. A qualified clinical reviewer (BCBA, BCBA-D) conducts HNFS' clinical necessity reviews and clinical consultations. These reviews help determine what a beneficiary needs based on treatment history and how well the beneficiary is responding to current treatment.

Clinical necessity reviews ensure the treatment plan coincides with the most appropriate level of care by performing:

- A review of the clinical treatment documentation and data.
- An evaluation of the treatment plan.
- An evaluation of the standardized outcome measures.

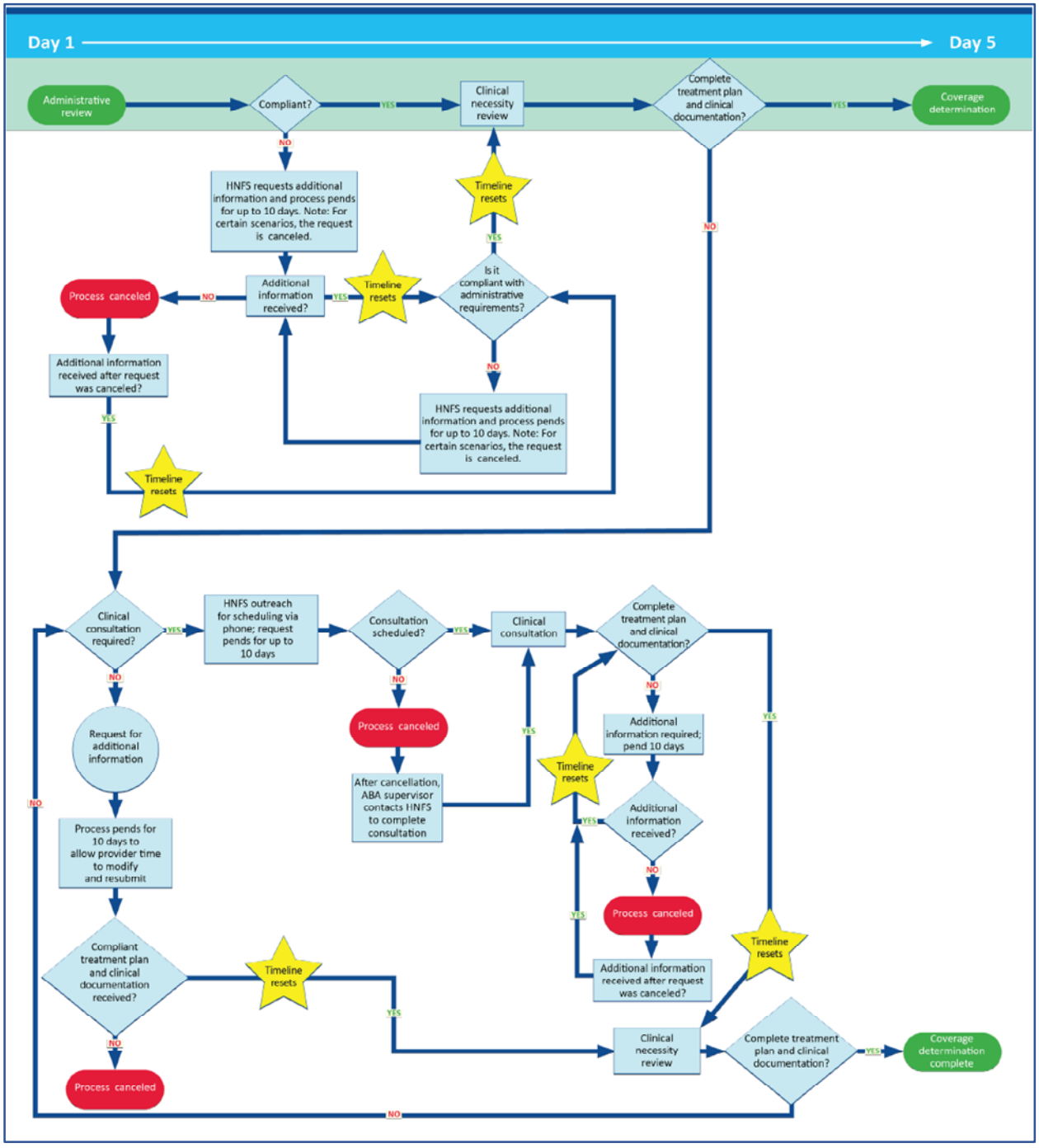
The clinical reviewer will consider the following overarching areas for clinical necessity:

- Level of clinical support
- Treatment plan
- Dose response (intensity, frequency, duration)
- Duration of services
- Other rendered services

To learn more about clinical necessity reviews and details on submitting a compliant treatment authorization request, visit our **Clinical Necessity Reviews** page.

Refer to **"Clinical Necessity Review Process"** in this section for a visual depiction of the clinical necessity review process and **(Section 8.0) Top Reasons for Delayed Treatment Authorizations** of this training for clinical necessity review tips.

Clinical Necessity Review Process



Clinical Consultations

If needed, an HNFS clinical necessity reviewer will request additional information or schedule a clinical consultation with an ABA provider *prior to issuing a determination of coverage*.

During the clinical consultation, the clinical necessity reviewer will address:

- Areas of clinical necessity.
- Goals and recommendations.
- Location of services, if applicable (for example, school, community).
- Areas that need to be revised or removed in the treatment plan (for example, exclusions, goals targeting comorbid diagnoses).

Following the clinical consultation, the ABA provider will receive:

- Written notification containing items addressed during the consultation.
- Required modifications.
- Directions on how to resubmit a request for authorization, if applicable.

If applicable, once HNFS has received the resubmitted authorization request:

- A second review will be performed.
- A coverage determination of ABA services will be completed.

Requests with outstanding areas of concern may be subject to additional consultation or cancellation and require additional resubmissions.

As a reminder, ASNs do not conduct clinical necessity reviews or make coverage determinations.

Clinical Necessity Review and Clinical Consultation Process Time Frames

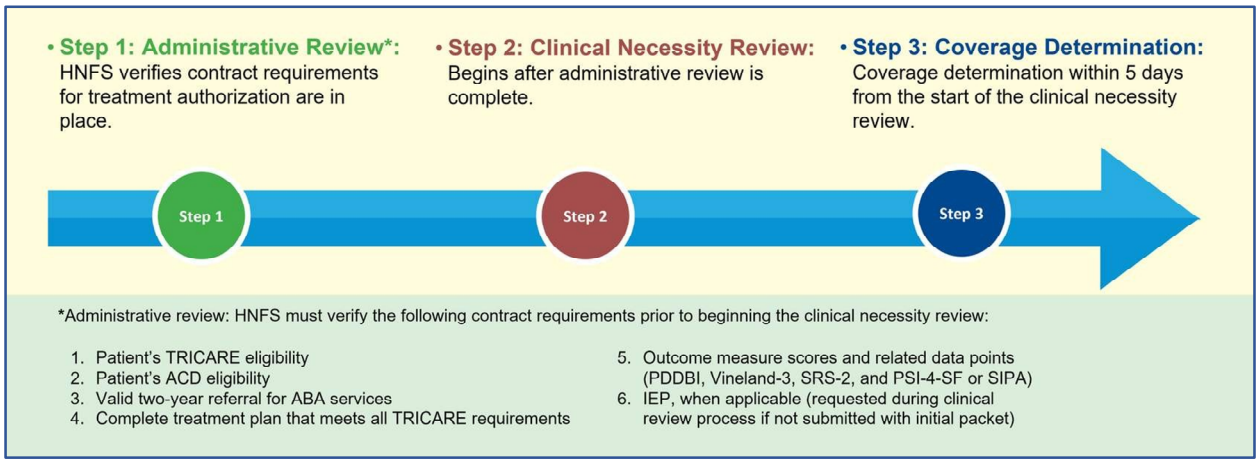
Clinical necessity reviews start once we have received a complete packet from an ABA provider and all program requirements have been met (eligibility, outcome measures, two-year referral, etc.).

- It takes HNFS up to five business days to complete the review.
- If we need additional information, we will ask for an updated treatment plan.
- Clinical necessity reviewers may request a consultation with the ABA supervisor to discuss elements of the treatment plan.
- After the consultation, we will either complete a coverage determination or request that a provider submit an updated treatment plan for further review.

Treatment Authorization Process

Compliant Request Packet Submission Example

Time frames vary according to the initial completeness/compliance of the administrative review and treatment authorization request packet submission. This graphic depicts the steps of a compliant submission.



To prevent possible gaps in care, ABA providers are responsible for responding in a timely manner to requests for consultation and/or additional information. Requests for reauthorization can be submitted up to 60 days in advance. ABA authorizations will not be backdated if there is a lapse in authorization.

Applied Behavior Analysis Service Settings

TRICARE allows for ABA services to be rendered in various settings, as clinically appropriate. Regardless of the setting, authorized ABA services must:

- Target core ASD symptoms.
- Not be an excluded service under the ACD.

Part of the clinical necessity review process includes determining the appropriate location for ABA services.

Setting	Details
Home	**The home is the beneficiary's residence.** • Services can be rendered by all ABA provider types (as authorized per the treatment plan). • The ABA provider must render active delivery of ABA services that target core ASD symptoms. • Refer to **"School"** in this section for home-school information.
Centers/Clinics	**A center/clinic is the outpatient ABA center or clinic.** • Services can be rendered by all ABA provider types (as authorized per the treatment plan). • The ABA provider must render active delivery of ABA services that target core ASD symptoms. • Travel to and from a center/clinic is not reimbursable.

Setting	Details
School	**A school is defined as a preschool, public school, or private school or home-school.** • Services only can be rendered by ABA supervisors (as authorized per the treatment plan) and all requirements must be met. • The ABA supervisor must render active delivery of ABA services that target core ASD symptoms. • Focused, time-limited services. • ABA services performed by BTs or assistant behavior analysts in a school setting are not allowed. • The ABA supervisor may not function as a support aide or observer during school routines or activities (lunch, group activities, arts and crafts, etc.). • A current IEP is required. ABA services may not duplicate IEP services or goals. • Academic or educational goals are not covered under the ACD in any setting, including the school setting. • Authorized ABA services must be rendered outside of home-school instruction. Home-school instruction cannot overlap ABA services. • Daycare centers/child development centers/after-school programs are not considered school settings under the ACD. Refer to **"Daycare"** in this section.
Daycare (Non-Preschool)	**A daycare is a daycare center, child development center or after-school program.** • Services may be rendered by all ABA provider types (as authorized per the treatment plan). • The ABA provider must render active delivery of ABA services that target core ASD symptoms. • ABA providers may not function as support aides or observers during daycare routines or activities (lunch, group activities, arts and crafts, etc.).

Setting	Details
Community	**Community settings are any location not part of a home, center/clinic or school setting, such as grocery stores, parks, restaurants, medical offices, or events like youth sports or local community events.** • Services may be rendered by all ABA provider types (as authorized per the treatment plan). • The ABA provider must render active delivery of ABA services that target core ASD symptoms. • Focused, time-limited services. • Specific exclusions apply to sporting events, camps and medical appointments (doctor visits, PT, etc.), to include another family member's appointments. • Because community settings often do not allow for frequent/repeated treatment opportunities and often target areas not specific to an ASD diagnosis, we use the clinical necessity review process to determine whether a community setting is clinically appropriate (provider types, units, etc.). • Parent/caregiver training cannot be performed in a community setting and must be conducted in a clinic or home setting or by telemedicine (when authorized).

Telemedicine	**Telemedicine is the use of secure video conferencing to provide active delivery of ABA services to beneficiaries at home.**
	• Audio-only services are not allowed.
	• When authorized, only the following services are allowed via telemedicine:
	  ○ Parent/caregiver guidance by the ABA supervisor or assistant behavior analyst
	  ○ Medical team conferences by the ABA supervisor
	• The ABA supervisor or assistant behavior analyst must render active delivery of ABA services that target core ASD symptoms.
	• BTs may not provide services via telemedicine.
	• Outcome measures are not allowed via telemedicine but may be rendered via indirect methods (refer to **"Indirect"** in this section).

Indirect	**Indirect refers to email and U.S. postal mail (report writing, reviewing records, etc.).** Outcome measures may be performed by TRICARE-authorized ASD diagnosing providers or, when authorized by HNFS, ABA supervisors via indirect methods.

Exclusions

ABA services are not covered for symptoms and/or behaviors that are not part of the core ASD symptoms. ***HNFS will require ABA providers to remove all excluded services from treatment plans prior to a coverage determination.***

Goal-Related Exclusions

- Goals targeting activities of daily living (ADL). The principles of ABA (such as, backward chaining, schedules of reinforcement, etc.) may be targeted in direct treatment as a goal that once mastered can be generalized for parent/caregiver goals under CPT code 97156 to introduce parents/caregivers to teaching ADLs outside of ABA services.
- Any target or goal that includes teaching how to complete or correctly complete an excluded task.
- Goals that address areas not related to core ASD symptoms of communication, social delay or restricted and repetitive behavior.
- Goals targeting symptoms and/or behaviors that are not part of core ASD symptoms, such as impulsivity due to attention-deficit/hyperactivity disorder (ADHD), reading difficulties due to learning disability, excessive worry due to anxiety disorder, etc.
- Opportunities where active delivery of services cannot occur.
- Goals targeting educational or vocational areas.
- Reading comprehension that is academic in nature and/or not related to core ASD symptoms.
- Items that are labeled social or communication-focused but still meet the definition of an ADL or academic objective (for example, will engage in socially acceptable levels of homework, will label the main character and plot of a book, will complete chores at a socially appropriate amount, etc.).
- Goals targeting specific motor actions or motor planning (for example, oral imitation, "will grip items using pincer grasp," "will walk up stairs," "will use sequence of movements," etc.). These will require modification or will not be covered.

Visit our **Exclusions** page for more information on goals and TRICARE policy exclusions.

Rendered hours for exclusions documented in session notes and billed to TRICARE will be recouped even if the goals are not in the treatment plan.

Refer to TOM, Chapter 18, Section 4 for the complete list of exclusions.

(Section 7.3) Applied Behavior Analysis Referrals and Reauthorizations (Step 4)

Step 4: Providing Applied Behavior Analysis Services

You've completed the clinical necessity review and have an approved authorization from HNFS – you're ready to provide treatment!

Access-to-Care Standards – Treatment

Now let's look at access-to-care standards as they apply to treatment.

- ABA providers must provide CPT codes 97153, 97155, 97156, 97157, or 97158-related services within 28 calendar days from the last date of service in the 14-day assessment (CPT code 97151) window.
- ABA providers must render the first session of parent/caregiver training (CPT codes 97156, 97157) within 30 calendar days of each treatment authorization and render a minimum of six parent/caregiver sessions every six months (CPT codes 97156, 97157).
- Authorized ABA supervisors must complete CPT code 97155 services at least one time per month. ***Failure to meet this requirement will result in a 10% penalty on all ABA claims for that beneficiary for the entire six-month authorized treatment period.*** (The penalty may be waived if no CPT code 97153-related services were rendered that month.)
- HNFS must verify the start date for treatment. If access-to-care standards are not met, HNFS will verify with the beneficiary and/or the provider the reported reason for the delay. If the beneficiary chooses to waive access-to-care standards, HNFS will require confirmation. ABA providers must respond to requests for confirmation of the first date of service.

TRICARE-Approved Adaptive Behavior Services CPT Codes

Only TRICARE-approved ABS CPT codes for ABA providers will be authorized and reimbursable. Please review TOM, Chapter 18, Section 4 for more information.

97151 – Behavior Identification Assessment

- May be rendered by authorized ABA supervisors (or delegated to assistant behavior analysts).
- Initial assessments approved for 32 units per authorization period.
- Reassessments approved for 24 units per authorization period.
- Approved units include the administration, scoring and analysis of PDDBI.
- Must be used within 14 calendar days of the first date of service.
- No telehealth.

97151 – Outcome Measures

- Units may be authorized under CPT code 97151 by HNFS for each additional outcome measure (SRS-2, Vineland-3, PSI-4-SF/SIPA) rendered by the authorized ABA supervisor (not delegated to the assistant).
- HNFS will issue a separate authorization for these outcome measures with one unit per measure authorized.
- For these outcome measure units, include modifier 99 on the claim form.

97153 – Adaptive Behavior Treatment by Protocol

- Rendered by authorized ABA supervisors (or delegated to assistant behavior analyst) and BTs.
- School setting:

- Rendered by ABA supervisors only.
  - Must be approved through the clinical necessity review process.
  - Services are focused, time-limited, and in accordance with the requirements of the ACD.
- May not exceed 32 units per day or 160 units per week.
- Fifteen minutes per unit.
- No telehealth.

97155 – Adaptive Behavior Treatment by Protocol Modification

- Rendered by authorized ABA supervisors (or delegated to assistant behavior analyst).
- At least one session per month must be rendered by the authorized ABA supervisor and cannot be delegated to an assistant behavior analyst.
  - As of Aug. 1, 2021, subject to 10% penalty on all ABA claims for a beneficiary's entire six-month authorization if not met.
  - The 10% penalty may be waived if no CPT code 97153 services were rendered within the calendar month.
- Team meetings and IEP meetings excluded.
- May not exceed eight units per day.
- Fifteen minutes per unit.
- No telehealth.

97156 – Family Adaptive Behavior Treatment Guidance

- Rendered by authorized ABA supervisor (or delegated to assistant behavior analyst).
- May not exceed eight units per day.
- Fifteen minutes per unit.
- ABA providers must render the first session of parent/caregiver training (CPT codes 97156 or 97157) within 30 calendar days of each treatment authorization.
- Six parent/caregiver sessions every six months (CPT codes 97156 and/or 97157).
- After first six-month authorization period, may be rendered via telehealth if authorized. Specific criteria apply. Refer to our **ABA Service Settings/Locations** page for details.

97157 – Multiple-Family Group Adaptive Behavior Treatment Guidance

- Rendered by ABA supervisor (or delegated to assistant behavior analyst).
- May not exceed six units per day and eight participants per group. May only be used in an office/clinic setting.
- Fifteen minutes per unit.
- ABA providers must render the first session of parent/caregiver training (CPT codes 97156 or 97157) within 30 calendar days of each treatment authorization.

- Six parent/caregiver sessions every six months (CPT codes 97156 and/or 97157).
- No telehealth.

97158 – Group Adaptive Behavior Treatment by Protocol Modification

- Rendered by ABA supervisor (or delegated to assistant behavior analyst).
- May not exceed six units per day and eight participants per group.
- Fifteen minutes per unit.
- No telehealth.

99366 and 99368 – Medical Team Conference

- Rendered by ABA supervisor.
- Minimum of three qualified health professionals from different specialties who have performed face-to-face evaluations or treatments with the beneficiary within the previous 60 calendar days. (Refer to TOM, Chapter 18, Section 4, paragraph 8.11.6.2.7 for more information.)
- CPT code 99366 is medical team conference with beneficiary present; CPT code 99368 is without beneficiary present.
- Beneficiaries with an assigned ASN must have the ASN present for the duration of the medical team conference for ABA providers to be paid.
- HNFS will authorize one unit of CPT codes 99366 and 99368 on all treatment authorizations every six months.
- Face to face or telehealth permitted. Refer to our **ABA Service Settings/Locations** page for details.
- Services may not be provided through audio-only.

Parent/Caregiver Training

Use the time immediately following treatment authorization to conduct parent/caregiver training (CPT codes 97156, 97157) – either with the parent/caregiver or in small groups based on the authorized services – to begin teaching parents/caregivers basic ABA principles and initiate the development of parent/caregiver training goals.

- Engaging parents/caregivers early and often increases their confidence and competency in participating in the program and generalizing skills long term.
- Getting parent/caregiver training started as soon as possible following treatment authorization can help ABA providers meet access-to-care standards for treatment.

Unit Modifications

Providers may request a change to the number of units authorized by HNFS by submitting a new request for ongoing services. Unit modification requests are typically submitted when there is a significant change in the clinical status of the beneficiary, resulting in a modification to the treatment plan and recommended units. If approved, HNFS will update the existing treatment authorization.

This new request must:

- Include an updated treatment plan that documents the reason for the change and any applicable modifications to the beneficiary's goals.
- Specify the requested units for all CPT codes.

To view detailed information regarding unit modifications, please refer to our **Authorization Changes** page.

Subsequent Authorizations

If continued treatment and ABA services are clinically indicated, ABA providers must submit an online request for reauthorization prior to the expiration of each six-month authorized treatment period. ABA providers can submit this as early as 60 calendar days in advance, but it must be submitted no later than 30 calendar days in advance.

Refer to **"Two-Year Referral and Reauthorization of Treatment Process"** in this section for a visual depiction of the reauthorization process.

For each reassessment and subsequent treatment request, HNFS will use the same clinical necessity review process conducted during the first treatment authorization.

These reviews cover:

- TRICARE eligibility
- ACD eligibility
- Updated treatment plans documenting beneficiary progress
- PDDBI Parent and Teacher Form scores

  Note: PDDBI Teacher Forms must be completed by the ABA supervisor and cannot be delegated.
- Outcome measures
- An IEP, when applicable
- Current two-year referral
- For beneficiaries with assigned ASNs, a current CCP that has been updated within the last six months

For each subsequent treatment plan, the following additional information must be included:

- Evaluation of progress on each treatment target
- Description of progress toward short- and long-term treatment goals
- Graphic representation or objective measurement tool consistent with baseline assessment
- Interventions that were ineffective and required modification
- Modifications that were the result of the outcome measures
- New behavior targets, objectives and goals
- Modifications based on the PDDBI and outcome measure results

- Revisions to address any lack of progress

For each subsequent clinical necessity review, HNFS also will include a review of the following:

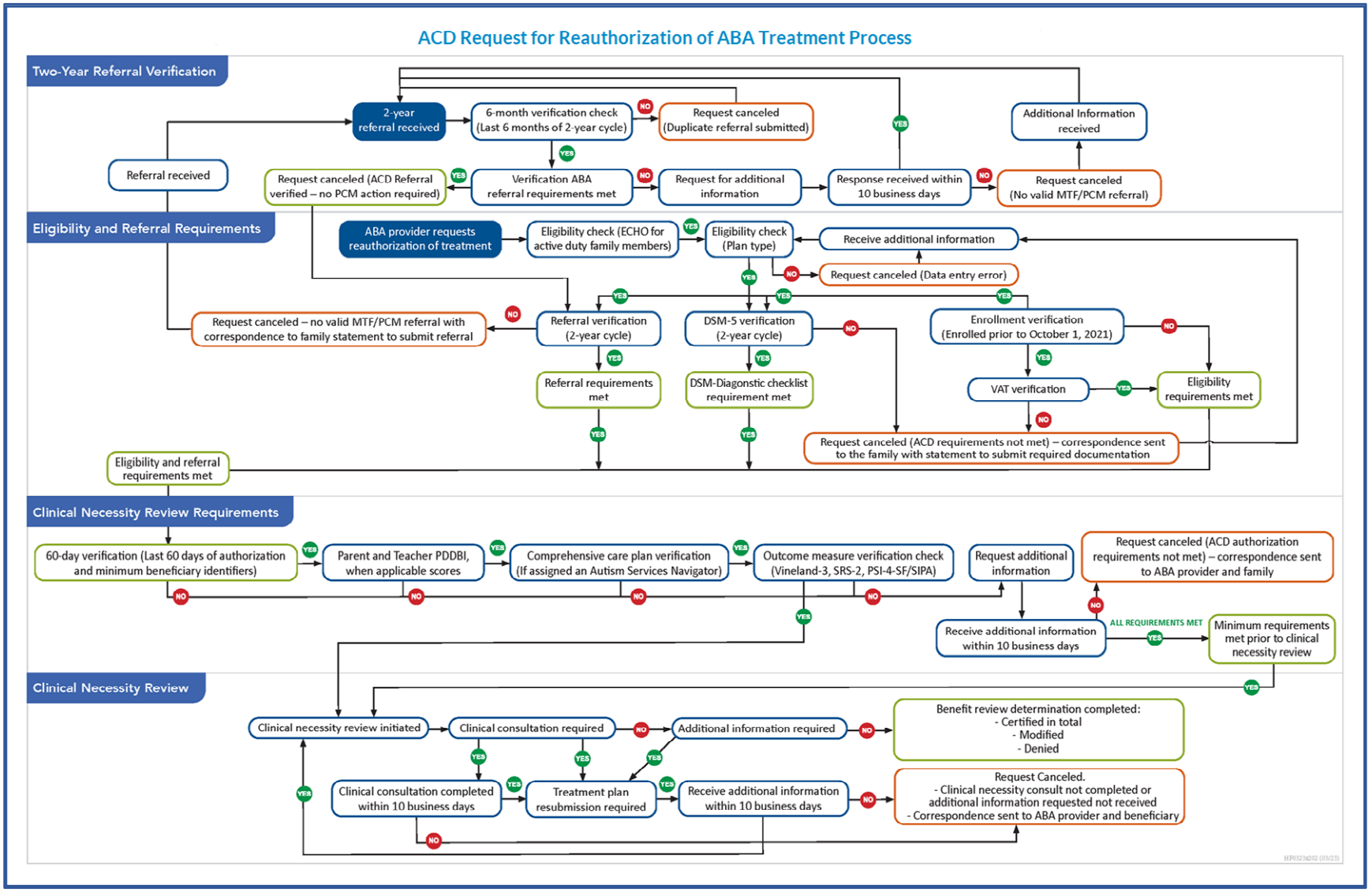
- Progress toward improved symptom presentation
- Parent/caregiver engagement
- Outcome measure-specific improvement, stagnation or regression

Referral Cycle Check

HNFS performs a referral cycle check to verify referrals are within the two-year cycle after receiving requests for reauthorization. Refer to **"Two-Year Referral and Reauthorization of Treatment Process"** in this section for a visual depiction of the reauthorization process.

- Remember, the two-year timeline for referrals begins on the date HNFS verifies the referral. Since the referral for ABA services is valid for two years, a new referral is not required for each six-month treatment authorization renewal period.
- If the referral cycle due date is past the date of the next reauthorization start date, HNFS will request the beneficiary obtain an updated referral prior to approval.
- If a new referral is required, we will cancel the treatment request and notify the ABA provider and the beneficiary.
    - The beneficiary should contact their TRICARE-authorized ASD diagnosing and referring provider and request a referral for ABA services be submitted to HNFS.
    - For referrals that initiated from a military hospital or clinic, HNFS will contact the military hospital or clinic directly to submit the referral.

Two-Year Referral and Reauthorization of Treatment Process



Discharge Planning

The discharge plan must be unique to the beneficiary, and ABA providers must update discharge plans as needed based on the beneficiary's response to treatment. ABA providers can use discharge plans to help families successfully transition to a parent/caregiver training model. Discharge plans should be updated at every six-month reauthorization.

When the ABA provider recommends the beneficiary be discharged from his or her care or ABA services, providers must submit a discharge summary report once a beneficiary's transition is complete.

- The writing of the discharge report is not a billable activity.
- Submission of discharge reports should be managed through our online authorization submission tool, **CareAffiliate** (login required).
- Termination from ABA services must not occur abruptly. At a minimum, please notify both HNFS and the beneficiary 45 days prior to termination.
    - If termination from ABA services is unrelated to improved symptomatology (for example, meeting program goals, reduced level of clinical necessity) but is instead due to safety issues, parent/caregiver compliance or company closures, the ABA provider must call our ACD customer service line to provide a timeline for the transition and the justification for the termination.
    - Providers also are instructed to contact our ACD customer service line to address and provide a timeline for program holds due to safety-related issues that must be resolved prior to restarting programming.
- ABA providers must notify HNFS by calling our ACD customer service line and submitting a discharge summary report. ABA providers should not contact referring providers (PCM, military hospitals and clinics) when discharging.
- If a family terminates services prior to the full 45-day notice or for other circumstances beyond the provider's control, the provider must notify HNFS and submit a discharge summary report that includes the reason for the early termination.
- ABA providers and beneficiaries can contact our ACD customer service line if they need help during the discharge process and/or to discuss any concerns.

Important!

HNFS will notify military hospitals and clinics about terminations. ABA providers should not notify military hospitals and clinics about terminations.

Second Opinions on Discharge

- Beneficiaries or the family may request a second opinion from a different ABA provider to obtain another clinical recommendation or plan of care. Please direct beneficiaries who have been notified of discharge but would like a second opinion to contact our **ACD customer service line**.

- Second opinions follow the same referral, access-to-care, treatment plan, outcome measure, and process requirements as an initial assessment. (ABA providers should not contact referring providers as a new referral ***is not required*** for the beneficiary to seek a second opinion if the referral is within the two-year cycle.)
- The second opinion assessment can be completed by a different ABA provider, but only one ABA provider may be authorized to provide treatment at a time.

Learn more about discharge criteria specifics in TOM, Chapter 18, Section 4 and at www.tricare-west.com/go/ACD-provider.

(Section 8.0) Top Reasons for Delayed Treatment Authorizations

Pre-Clinical Necessity Review Screening: Missing or Inaccurate Information

When HNFS receives a treatment request or a reauthorization request, we do a prescreening to make sure the request is complete for moving on to clinical necessity review. During this prescreening process, our reviewers have reported the following issues as the most common reasons for determining requests as incomplete:

- Location of services did not include CPT codes.
- Location of services did not clearly indicate the location where each CPT code would be used (for example, location of services was embedded).
- The treatment plan did not identify recommended units for each requested CPT code.
- The treatment plan did not include the location(s) of the rendered service(s).
- The treatment plan did not include or listed incorrect beneficiary information, such as:
  - Incorrect date of birth
  - Missing sponsor SSN or DBN
  - Misspelled name (or the beneficiary's nickname was listed in the treatment plan instead of the beneficiary's legal name)
  - Missing the date that the treatment plan was updated (to confirm in the last 60 days of the authorized treatment period)
- The treatment plan had the PDDBI embedded instead of submitted separately as a completed publisher's form.
- Treatment plans and requests not submitted a minimum of 30 calendar days before the end of the current authorized treatment period.

Clinical Necessity Review: Missing or Insufficient Information

More than 75% of treatment and reauthorization requests HNFS receives do not meet the minimum requirements for HNFS to authorize treatment and require the ABA provider to make changes before HNFS can issue a coverage determination. The top issues observed by HNFS' clinical necessity reviewers include:

- Lack of detailed information explaining outcome measure stagnation or regression
- Missing or inadequate goal criteria
- Missing or vague discharge criteria
- Discharge criteria not individualized to the beneficiary
- Missing or insufficient documentation of requirements and justifications for school and community locations
- Minimum session documentation of parent/caregiver training
- Vagueness or lack of detail in progress summaries (for example, only stating minimum requirements were met, and not detailing the sessions completed)

Goals: Missing or Insufficient Details

Goals included in treatment plans must have measurable targets and apply to the DSM-5 criteria. Goals should:

- Include objective criteria in baseline and goal mastery, avoiding subjective criteria (for example, will engage in moderate duration conversation versus will engage in five-minute conversations, etc.).
- Outline what skill/area is being addressed using objective measures that do not reference curriculum when targeting specific curriculums (for example, Promoting Emergence of Advanced Knowledge [PEAK]).
- Target what the parent/caregiver is learning or implementing and not solely focus on the beneficiary's performance (for parent/caregiver training goals).
- Not target an excluded task.
- Not list baseline as "will be collected once goal is introduced" or something similar.

Community and School Locations: Insufficient Justification or Reason

Requests with community locations should:

- List detailed, specific locations.
- Provide details about what goals will be targeted in which locations and what provider type(s) will offer services in which locations.

- Include detailed descriptions and rationale for the location.

Requests for school locations should:

- Indicate which goals will be targeted and how long the location will be used for ABA treatment. The service location should only be used for a limited time and scope (six to 12 months or shorter, proportional amount of goals, etc.).
- Not be used by the ABA supervisor to shadow the beneficiary or observe or train school staff or provide other non-direct treatment.
- Goals must remain specific to core ASD symptoms and cannot include academic/educational exclusions.
- Goals should be clearly identified and not overlap with IEP goals. This means that if school staff are also targeting a goal area, the ABA provider cannot target this in the school setting. As part of their review, clinical necessity reviewers compare IEP and ABA treatment goals.
- Home-schooling is not included in this allowance and home-schooling instruction cannot overlap with approved ABA treatment. When reporting on the number of hours per week or when scheduled home-schooling instruction occurs, please be as specific as possible to ensure reviewers can assess if ABA programming may overlap.

Outcome Measures: Insufficient or Missing Details and/or Rationale

Treatment plans should explain negatively changing outcome measure scores by:

- Directly acknowledging stagnant progress and/or lack of progress as indicated by outcome measure scores and including corresponding treatment adjustments to mitigate lack of progress (goals, CPT recommendations, etc.) and/or rationale for observed stagnant or worsening outcome measure scores (gap in care, comorbid diagnosis, new home location, etc.).

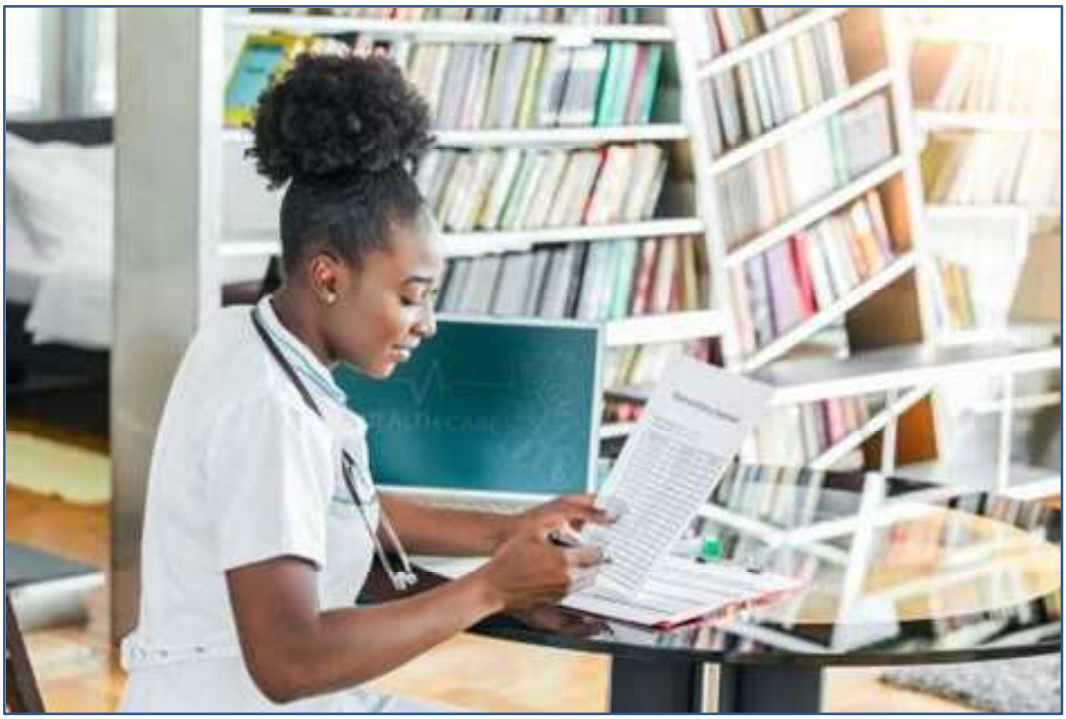
  Note: Treatment plans containing this information may reduce the need for a clinical consultation with a clinical necessity reviewer. However, when stagnation and lack of progress persist over multiple six-month reporting periods, a clinical consultation may be required to fully understand long-term planning.
- Investigating the domain and subdomain scores and the responses that drive the lack of progress in observed score changes that represent a lack of progress. Investigation results should be used to modify treatment goals or remove barriers to progress (stimulus control, strength of reinforcement contingencies for areas identified as not progressing, gaps in care, etc.) and demonstrate that score regression is being sufficiently addressed.
- Considering how a respondent's answers – or variations across a respondent's answers – have influenced outcome measures when the ABA supervisor has observed changes in scores indicating lack of progress. ABA supervisors are encouraged to ask respondents for additional details to ensure large variances in scores are not the result of inconsistent responses. This includes instances of large discrepancies in scores between the PDDBI Parent and Teacher Forms, which should be addressed in treatment planning.

(Section 9.0) Reimbursement and Billing

Reimbursement

> **Refer to TOM, Chapter 18, Section 4 and www.tricare-west.com/go/ACD-provider for complete details.**

Electronic Funds Transfer



TRICARE requires HNFS to reimburse sole ABA providers and ACSPs for ACD services via electronic funds transfer (EFT). If you are a sole ABA provider or ACSP who has not yet signed up for EFT, visit our **EFT/ERA** page to get started.

> **Important!**
>
> **New enrollments can take up to 45 days to process once all information has been received.**

Cost-Sharing

- Deductibles, cost-shares and copayments are based on the beneficiary's qualifying **TRICARE plan type** (such as TRICARE Prime, TRICARE Select, etc.).
- No maximum payment or annual cap for ABA services.

- One copayment for all ABA services rendered on the same day. Non-ABA services rendered on the same day will follow normal rules.
- One copayment for the 14-calendar day period for CPT code 97151.
- All services under the ACD require pre-authorization, even for beneficiaries who have OHI. All ACD program, referral and authorization requirements must be met with the OHI.

Rates

Reimbursement rates are based on independent analyses of commercial and CMS' ABA rates and vary by geographic locality. Visit **www.health.mil/rates** to view current rates.

Balance Billing

ABA providers may not bill the beneficiary more than 100% of the rates posted at **www.health.mil/rates**. The balance billing guidelines defined in TRICARE Reimbursement Manual (TRM), Chapter 3, Section 1, Paragraph 4.0 do not apply.

Hold Harmless

Network providers cannot bill a TRICARE beneficiary for non-covered care unless the beneficiary was informed in advance the care was not covered by TRICARE and agreed in advance and in writing to pay for the specific non-covered care.

Understanding Units of Service

Weekly (CPT Code 97153)

- The week is defined as Sunday to Saturday.
- Weekly CPT code 97153 units cannot be rolled over to other weeks.

Monthly (CPT Codes 97155, 97156, 97157, 97158)

- The first month begins the day services are authorized to start and ends on the last date of that month. Each month thereafter is based on the calendar month. **Example:** If the authorization starts Feb. 9, 2024, the first month is Feb. 9-Feb. 29, 2024, and the second month is March 1-March 31, 2024.
- Monthly units authorized for CPT codes 97155, 97156, 97157, and 97158 cannot be rolled over to other months.

Covering the Six-Month Authorization (CPT Codes 97151, 99366, 99368)

- These CPT codes (97151, 99366, 99368) can be billed during any month of the authorized treatment period.
- Reassessments should only occur within the last 60-80 days of the authorized treatment period.

Medically Unlikely Edits

- The DHA determines the maximum number of units allowed to be billed per day for each CPT code.
- Medically unlikely edits (MUE) are fixed and claims will deny if exceeded.

Concurrent Billing

Concurrent billing is excluded 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.

Refer to the "Concurrent Billing" section of our **Billing** page for complete details.

Guidelines

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

What to Include in Claims

- **Name of the rendering provider.** For each ABA service delivered (box 24 of the 1500 claim form).
- **NPI.** For each rendering provider.
- **Billing provider.** Per TRICARE policy and the American Medical Association's (AMA) CPT guidelines, assistant behavior analysts and BTs may not be listed as the billing provider or bill for any ABA services, as they are not independent providers according to their certifications.
- **Taxonomy.** All claims must include the *Health Insurance Portability and Accountability Act* (HIPAA) taxonomy designation of each provider type including:
  - 103K00000X – Behavior Analyst (for master's degree level and above)
  - 106E00000X – Assistant Behavior Analyst
  - 106S00000X – Behavior Technician
  - Other appropriate HIPAA taxonomy based on license/certification
- **TRICARE-approved CPT codes.** Only TRICARE-approved ABS CPT codes.
- **Session times.** Include the start and end time for all CPT codes using military time (HHMM). Claims billed without session times on each line and in military format will reject and need to be resubmitted. Document the session start and end times in one of the following locations.

  Important: Do not include a hyphen between times.

  - **For an electronic data interchange (EDI) claim:** Put the session times in Loop 2400 for each individual line note.

- **For XpressClaims:** Put the session times in each individual line note.

Incorrect:

Line one indicates 8 units of CPT code 97153; the line note includes session times of 0800 0900 and 1300 1400.

Correct:

- **Line one indicates 4 units of CPT code 97153; the line note includes a session time of 0800 0900.**
- **Line two indicates 4 units of CPT code 97153; the line note includes a session time of 1300 1400.**

- **Unique lines for services billed.** TRICARE requires that every session of ABA services be identified as its own unique line on claims submitted. (Refer to TOM, Chapter 18, Section 4.) When billing for multiple services rendered on the same day by the same rendering provider, you must separate out sessions, even if the CPT code is the same. Claims billed with multiple sessions on one line will reject and need to be resubmitted.
- **Modifiers.** TRICARE requires the use of specific modifiers to indicate patient presence and/or remote sessions. Adding a note such as "patient not present" or "patient with RBT" does not meet this requirement. Use the following modifiers as applicable:
  - HR – Family/couple with client present
  - HS – Family/couple without client present
  - GT or 95 – Parent/caregiver remote sessions
  - 99 – Use with CPT code 97151 to identify outcome measures (Vineland-3, SRS-2, PSI-4-SF/SIPA)
- **Place of service.** HNFS will make specific coverage determinations for ABA service locations. ABA providers should familiarize themselves with TRICARE requirements for the various location settings.
  - 02 (Telehealth)
  - 03 (School)
  - 11 (Office/Clinic)
  - 12 (Home)
  - 99 (Other) – For example, daycare, community settings

  Note: Additional information on location setting codes is available at the CMS' **Place of Service Code Set** page.
- **Medical team conference (CPT codes 99366 and 99368).** HNFS will authorize one unit of CPT codes 99366 and 99368 for each six-month authorized treatment period.
  - Include special processing code "AS" when billing CPT codes 99366 and 99368.
  - Do not report CPT codes 99366 and 99368 more than once for individuals from the same specialty at the same encounter.
  - Include modifiers to indicate if client was present (not required).

(Section 10.0) Progress Notes

General Information

Progress notes, also referred to as narrative summaries or session notes, are an important and required component of the ACD. Rendering providers must maintain progress notes that relate to the goals and objectives outlined in the beneficiary's treatment plan and that correspond with ABA claims filed with the beneficiary.

- **Providers are not required to submit progress notes with ABA claims; however, HNFS may request them for claims payment during an audit.**
- **HNFS will compare progress notes to a provider's claims to verify all required documentation.**

Progress notes must:

- Meet requirements stated in TRICARE Policy Manual (TPM), Chapter 1, Section 5.1.
- Contain all elements outlined in the TOM, Chapter 18, Section 4. These include but are not limited to:
  - Beneficiary's full name (not initials).
  - The date and time of session to include start and end times.
  - Length of session.
  - Location of rendered services.

- Rendering provider's name and license or certification.
- Dated signature.

  Important: The dated signature refers to the date the progress note was signed and may differ from the progress note's session date. The date of the session alone will not meet the dated signature requirement.
- Name of authorized ABA supervisor (if different than the rendering provider).
- Names of session participants (excluding other beneficiaries for CPT codes 97157 and 97158).
- For CPT codes 99366 and 99368, reporting participants' documentation of their roles in the medical team conference, contributed information and subsequent treatment recommendations.
- Beneficiary's current clinical status.
- Narrative summaries of session content that include CPT codes relevant to the services provided during the session. This narrative should be objective, specific and individualized to the session.
- Description of the ABA techniques used, response to treatment, the outcomes of the treatment, and the response to significant others (group session notes must contain individualized responses to treatment).
- Statement summarizing the patient's degree of progress toward the treatment goals.

- Reflect services detailed in corresponding claim.
  - Rendering provider (type of provider and name) and name of ABA supervisor (if applicable)
  - CPT code billed
  - Units billed
  - Location of rendered services (place of service)

The progress note requirements above are not all inclusive. Additional requirements are outlined in TOM, Chapter 18, Section 4.

Key Requirements

Some key requirements that may be new to ABA providers include:

- Location of rendered services
- Name of authorized ABA supervisor
- Name of all session participants (excluding other beneficiaries in group settings)
- Group session specifics
- Medical team conference participants' documentation
- Rendering provider's dated signature (Refer to important information about dated signatures in **"General Information"** of this section.)

Common Mistakes With Progress Notes

Approximately 65% of all progress notes submitted to HNFS contain errors. The most frequently noted progress note mistakes observed by HNFS' reviewers include:

- **Missing a required element.** Elements commonly missed include:
  - Location of rendered services
  - Session participants
  - Rendering provider's license or certification
  - Rendering provider's dated signature (Refer to important information about dated signatures in **"General Information"** of this section.)

- Name of authorized ABA supervisor
- Clinical status (includes CPT code 97155 and CPT code 97156 [if the beneficiary is present])
- Progress toward goals for CPT code 97155
- Progress toward parent/caregiver goals for CPT codes 97156 and 97157

- **Incomplete content summary.**
  - Does not support the CPT code on the claim.
  - Does not provide details and examples of the services that were provided.
  - Does not support the services performed for the duration of the session.
- **Lack of supportive details (CPT code 97155).**
  - Does not support a change or addition to the protocol.
  - Does not explain why changes are not needed.
- **Billing for excluded areas.** For example:
  - Academics
  - ADLs
  - Vocational
- **Billing for team meetings.** Team meetings – including CPT code 97155 billed for meetings with school personnel – are not reimbursable under the ACD.
  - This includes attendance at IEP meetings.
  - This applies to all beneficiaries under the ACD, whether or not they are approved to receive services in the school setting.
- **Billing for supervision.** Oversight and supervision of BTs and assistant behavior analysts is required as clinically appropriate and in accordance with the BACB guidelines and ethics but is not billable under the ACD.

(Section 11.0) Compliance and Audits

Medical Record Documentation and Billing Compliance

Providers must ensure their medical documentation and billing practices always comply with TRICARE requirements; state and federal regulations; and provider participation agreements, policies and guidelines.

Strictly adhere to TRICARE requirements in the following areas:

- Progress notes
- Exclusions
- TRICARE-approved ABS CPT codes
- Medical documentation supports what is billed on the claim
- Billed services and activities are consistent with the approved treatment plan
- TRICARE's telemedicine exclusions specific to the ACD

Tools and resources are available at www.tricare-west.com/go/ACD-provider.

Audit Frequency (Existing and New Providers)

Existing and new ACSP groups and sole ABA providers are subject to record reviews.

Existing Providers

Existing ACSPs/sole ABA providers are subject to a minimum of 30 record reviews annually. These include administrative and medical documentation reviews and a review of one medical team conference progress note (if available).

In a separate review process, HNFS also looks at CPT code billing practices of West Region ABA providers to ensure compliance with TOM requirements.

New Providers

HNFS monitors all new network and non-network ACSPs/sole ABA providers during their initial 180 days of participation in the West Region.

- New providers are not required to have the 30 annual audits that existing ABA providers must have.
- Following the initial 180 days, we will review a minimum of 10 records. These include administrative and medical documentation reviews to audit for consistency with program requirements.
- If the reviewer finds inconsistencies with meeting program requirements during an audit, we will share results with the provider; give them written education; and, if necessary, arrange a videoconference with the provider.

Audit Types

CPT Code

HNFS reviews billing practices of ABA providers to ensure compliance with ACD and TRICARE-approved ABS CPT code requirements. This includes verifying ABA supervisors rendered a minimum of one direct visit per month for CPT code 97155 (cannot be delegated to an assistant behavior analyst).

IMPORTANT: A 10% penalty will be applied to all ABA claims in an authorized treatment period if the CPT code 97155 requirement detailed above has not been met by the authorized ABA supervisor. *Exception: The 10% penalty may be waived if no CPT code 97153 services were rendered in a calendar month.*

Administrative

HNFS monitors ABA claims data to identify and prevent potentially fraudulent billing practices. Anti-fraud software is used to review claims data and detect potential issues. If suspect billing patterns are identified, we will engage providers to address the findings and provide education on TRICARE requirements to mitigate ongoing issues. HNFS will conduct a post-payment review within 180 calendar days to verify that any suspect billing patterns have been resolved.

Providers with ongoing suspect billing patterns will be referred to HNFS' Program Integrity Department.

Medical Documentation

Federal regulation requires legible medical record documentation be prepared as soon as possible after care is rendered. HNFS conducts medical record documentation reviews to ensure compliance with the requirements listed in TOM, Chapter 18, Section 4.

Reviewers:

- Evaluate whether claims are supported by corresponding medical documentation.
- Evaluate whether progress notes contain all required documentation elements according to TOM, Chapter 18, Section 4, Paragraph 8.7.2.
- Evaluate whether services documented in progress notes comply with TRICARE-approved ABS CPT codes.
- Ensure that exclusions were not rendered during the session.

During these reviews:

- HNFS contacts the ACSP/sole ABA provider to establish initial contact and verify contact information for the audit.
- HNFS sends a written medical documentation request to the ACSP/sole ABA provider. HNFS also may contact the ACSP/sole ABA provider regarding the written request.
- ACSP/sole ABA providers must promptly respond to HNFS' written requests.
- HNFS conducts a review to ensure medical documentation/records comply with ACD requirements.
    - If the audit results in no findings, HNFS does not send correspondence to the ACSP/sole ABA provider.
    - If the audit results in findings, HNFS sends the ACSP/sole ABA provider a written summary detailing education requirements or findings resulting in recoupment.

Audit Common Issues

Some of the most common audit issues encountered by HNFS' reviewers include:

- Leaving out progress notes when requested by HNFS for an audit. A provider should submit all progress notes pertaining to a request. If there were three sessions rendered for the CPT code and date of service requested, all three progress notes should be submitted for the audit.
- Submitting only a treatment plan for CPT code 97151.

- Using the beneficiary's initials instead of the beneficiary's full name.
- Documenting location as an address rather than a place of service (for example, home, office/clinic, etc.).
- Missing TOM requirements/elements (documentation).
- Missing clinical status and progress toward goals in progress notes for CPT code 97155.
- Missing clinical status (if beneficiary was present) and progress toward parent/caregiver goals for CPT codes 97156 and 97157.
- Lacking details and examples of the services provided/activities performed for the duration of the billed session in progress notes.
- Omitting supporting details in progress notes for CPT codes billed on the claim.
- Lacking detailed information in progress notes that makes it clear a session was used to actively implement ABA treatment plan goals for CPT code 97153.
- Missing details and information in progress notes that support a change or addition to protocol or explain why protocol change was not needed for CPT code 97155.
- Lacking supportive details or information in progress notes that show parent/caregiver training was rendered to the parent/caregiver for the duration of the session for CPT code 97156.

Audit Common Exclusions Identified

These are some of the most common exclusions encountered by HNFS' reviewers.

Exclusion	TOM Guideline
Billing for team meetings	Team meetings – including CPT code 97155 billed for meetings with school personnel – are not reimbursable under the ACD. This applies to all beneficiaries under the ACD, whether or not they are approved to receive services in the school setting.
Billing for supervision and training of BTs	Assistant behavior analysts and BTs must be supervised in accordance with their credentialing bodies, but billing for supervision is not permitted. This includes providing BTs' performance evaluations.
Remote delivery of ABA services	Unless explicitly stated as allowed by the TOM, remote delivery of ABA services is an exclusion.
Creation of office or therapeutic supplies	These are exclusions per TRICARE policy.
Educational/academic, vocational, rehabilitation, and other non-medical services	These are exclusions per TRICARE policy.
Report writing	This is an exclusion per TRICARE policy except for what is included in assessment for CPT code 97151.

Exclusion	TOM Guideline
Functional/ADL skills	These are exclusions per TRICARE policy.
ABA services provided while the beneficiary is at another medical appointment	Services provided during other medical appointments for the beneficiary or when the beneficiary is at another family member's medical appointment are exclusions per TRICARE policy.
Driving	Driving to and from ABA treatment appointments is an exclusion per TRICARE policy.
ABA services in the school setting	ABA services in the school setting are limited to the role of the authorized ABA supervisor who is targeting a specific behavior excess or deficit and is for a limited duration. Must be pre-authorized in the treatment plan for use in the school setting.

Refer to TOM, Chapter 18, Section 4 for a complete list of ACD exclusions.

Audit Outcomes

Audit findings may result in any (or all) of the following:

- Outreach and education
- Payment recoupment
- Referral to HNFS' Program Integrity Department
- Probe audit
- Placement into prepayment review

Tips for Success

Begin immediately: Make sure your medical documentation and billing practices comply with TRICARE requirements for the ACD prior to the initiation of any audit.

Some key (but not all inclusive) areas of TOM, Chapter 18, Section 4 include:

- Progress Note Documentation (8.7.2)
- Exclusions (8.9.8.1 and 8.10)
- ABS Approved CPT Codes (8.11.6)
- TRICARE's telemedicine exclusions that are specific to the ACD (8.10.8 [except as allowed under 8.11.6.2.4.9], 8.10.9 and 8.10.11)

(Section 12.0) Autism Care Demonstration Resources

Applied Behavior Analysis Providers

www.tricare-west.com/go/ACD-provider

- Extensive content on navigating the ACD
- Frequently asked questions
- Authorization and referral submission and status tools
- Provider directory
- Check credentialing status
- Check claims status
- Provider roster template
- Links to TRICARE policy manuals
- Education articles

www.health.mil/autism

- DHA-hosted presentations

- Frequently asked questions
- Reimbursement rates
- Links to TRICARE policy manuals
- Sign up for ACD-related email alerts

For Your TRICARE Patients

www.tricare-west.com/go/ACD

- *Parent Toolkit: New to the Autism Care Demonstration* – Designed to help parents/caregivers understand the building blocks of the ACD
- Frequently asked questions – ACD questions flyer
- ECHO registration information – Steps for registering in ECHO
- Provider directory – Locating local ABA providers
- Referral, authorization and claim status – Online tools to answer questions about referrals, authorizations and claims

www.familysupport.hnfs.com

- Directory of social service organizations
- Military and civilian support resources
- Local area support groups and resources
- Support groups and resources located on military installations

www.tricare.mil/autism

Access benefit-related information and an overview of the TRICARE program.

www.health.mil/autism

Sign up for ACD-related email alerts.

www.militaryonesource.mil

Get connected to resources, benefits and services.

(Section 13.0) Contacting Health Net Federal Services

As a reminder, you can reach HNFS' ACD customer service team by:

- Calling **1-844-866-WEST (9378)**, follow the prompts (Monday-Friday, 5 a.m.-9 p.m. PT), or
- Emailing us at **CS_ABA@hnfs.com**.

Who to Contact…

Topic	Contact Information
Claims questions	**1-844-866-WEST (9378)** Monday through Friday 5 a.m.-9 p.m. PT **www.tricare-west.com** > *Provider* > *Claims*, or **www.tricare-west.com/go/ACD-provider** > *Billing*
Contracting, Tax ID changes	Fax an updated W-9 along with a letter on company letterhead stating your requested changes to **1-866-312-4390** or email to **ACDNetwork@hnfs.com**.

Topic	Contact Information
Credentialing status	**1-844-866-WEST (9378)** Monday through Friday 5 a.m.-6 p.m. PT **www.tricare-west.com** > *Provider > Check Credentialing Status*
Demographic updates (phone number, location, attributes, etc.)	Submit an ABA provider roster to **HNFS_ABARosters@hnfs.com**. Be sure to include all required supporting documentation for BTs.
Session notes, medical documentation, claims audits	**1-844-866-WEST (9378)** Monday through Friday 5 a.m.-9 p.m. PT **ACDCommunications@hnfs.com** **www.tricare-west.com/go/ACD-provider** > *Medical Documentation (Progress Notes)*
Authorization letters	**www.tricare-west.com** > *Provider > Secure Tools > Secure Inbox (login required)*
Report access-to-care/start date changes to initial assessments and treatment authorizations	**ACDProviderAvailability@hnfs.com**
Provide updated availability for accepting new patients	**ACDProviderAvailability@hnfs.com**

(Section 14.0) List of Abbreviations and Acronyms

Abbreviation or Acronym	Definition
ABA	Applied behavior analysis
ABAT®	Applied Behavior Analysis Technician®
ABS	Adaptive behavior services
ACD	Autism Care Demonstration
ACSP	Autism Corporate Services Provider
ADFM	Active duty family member
ADHD	Attention-deficit/hyperactivity disorder
ADI®-R	Autism Diagnostic Interview – Revised
ADL	Activity of daily living
ADOS®-2	Autism Diagnostic Observation Schedule™, Second Edition
ADSM	Active duty service member
AMA	American Medical Association
ASD	Autism spectrum disorder
ASN	Autism Services Navigator
BACB®	Behavior Analyst Certification Board, Inc.®
BCaBA®	Board Certified Assistant Behavior Analyst®
BCAT	Board Certified Autism Technician
BCBA®	Board Certified Behavior Analyst®
BCBA-D®	Board Certified Behavior Analyst – Doctoral®
BICC	Behavioral Intervention Certification Council
BLS	Basic life support
BT	Behavior technician
CARS™-2	Childhood Autism Rating Scale™, Second Edition
CCP	Comprehensive care plan
CFR	Code of Federal Regulations
CHBC	Criminal history background check
CMS	Centers for Medicare & Medicaid Services
CPR	Cardiopulmonary resuscitation
CPT® code	Current Procedural Terminology code
DBN	Department of Defense Benefits Number
DEERS	Defense Enrollment Eligibility Reporting System
DHA	Defense Health Agency
DNP	Doctor of nursing practice
DOD	Department of Defense
DSM-5	*Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition
ECHO	Extended Care Health Option
EDI	Electronic data interchange
EFMP	Exceptional Family Member Program
EFT	Electronic funds transfer
GARS-3	Gilliam Autism Rating Scale, Third Edition

Abbreviation or Acronym	Definition
HIPAA	*Health Insurance Portability and Accountability Act*
HNFS	Health Net Federal Services, LLC
IEP	Individualized Education Program
IFSP	Individualized Family Service Plan
LABA	Licensed assistant behavior analyst
LBA	Licensed behavior analyst
MUE	Medically unlikely edit
NPI	National Provider Identifier
NPPES	National Plan & Provider Enumeration System
OHI	Other health insurance
OT	Occupational therapy
PCM	Primary care manager
PDDBI	Pervasive Developmental Disorder Behavior Inventory
PEAK	Promoting Emergence of Advanced Knowledge
PSI-4-SF	Parenting Stress Index, Fourth Edition Short Form
PT	Physical therapy
QABA®	Qualified Applied Behavior Analysis Credentialing Board
QASP-S®	Qualified Autism Service Practitioner – Supervisor
QHP	Qualified health professional
RBT®	Registered Behavior Technician®
SDC	Special Day Class
SIPA	Stress Index for Parents of Adolescents
SRS-2	Social Responsiveness Scale, Second Edition
SSN	Social Security number
ST	Speech therapy
STAT™	Screening Tool for Autism in Toddlers and Young Children
TIN	Tax Identification Number
TOM	TRICARE Operations Manual
TPM	TRICARE Policy Manual
TRM	TRICARE Reimbursement Manual
VAT	Validated assessment tool
Vineland-3	Vineland Adaptive Behavior Scales, Third Edition

Thank You

Health Net Federal Services values your commitment to the health and well-being of our uniformed services members, retirees and their families. As a trusted and respected health care professional, your participation in the TRICARE provider network is essential to the success of the program. We look forward to carrying on the vital mission of the TRICARE program and partnering with you to serve our military families.