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TRICARE  
MANAGEMENT ACTIVITY

**MB&RB**

**CHANGE 95  
6010.57-M  
AUGUST 22, 2013**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE POLICY MANUAL (TPM), FEBRUARY 2008**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

**CHANGE TITLE: COMPLIANCE DATE CHANGE FOR CONVERSION FROM INTERNATIONAL CLASSIFICATION OF DISEASES, 9TH REVISION (ICD-9) TO INTERNATIONAL CLASSIFICATION OF DISEASES, 10TH REVISION (ICD-10) CODING**

**CONREQ:** 16287

**PAGE CHANGE(S):** See page 2.

**SUMMARY OF CHANGE(S):** The Health Insurance Portability and Accountability Act (HIPAA) Final Rule published in the Federal Register on January 16, 2009, mandated nationwide conversion from ICD-9, Clinical Modification (ICD-9-CM) coding to ICD-10, Clinical Modification (ICD-10-CM) (diagnosis) and ICD-10, Procedure Coding System (ICD-10-PCS) (procedures). On September 5, 2012, the compliance date was changed to October 1, 2014, as part of a Final Rule published by Health and Human Services (HHS), for the ICD-10-CM and ICD-10-PCS Medical Data Code Sets. Language previously published in the TRICARE Operations Manual (TOM), TRICARE Policy Manual (TPM), TRICARE Reimbursement Manual (TRM), and TRICARE Systems Manual (TSM) is revised to include the new compliance date.

**EFFECTIVE DATE:** October 1, 2014.

**IMPLEMENTATION DATE:** October 1, 2014.

**This change is made in conjunction with Feb 2008 TOM, Change No. 103, Feb 2008 TRM, Change No. 85, and Feb 2008 TSM, Change No. 51.**

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**ATTACHMENT(S): 32 PAGE(S)  
DISTRIBUTION: 6010.57-M**

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT.

**CHANGE 95**  
**6010.57-M**  
**AUGUST 22, 2013**

**REMOVE PAGE(S)**

**CHAPTER 4**

Section 5.7, page 1

**CHAPTER 7**

Section 3.5, pages 1 through 4

Section 3.17, pages 1 and 2

Section 3.18, pages 1 through 19

Section 21.1, pages 1 and 2

**CHAPTER 8**

Section 2.6, pages 1 and 2

**CHAPTER 9**

Section 2.2, pages 1 and 2

Section 2.3, pages 1 and 2

**INSERT PAGE(S)**

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Section 3.18, pages 1 through 19

Section 21.1, pages 1 and 2

Section 2.6, pages 1 and 2

Section 2.2, page 1

Section 2.3, pages 1 and 2

## Gynecomastia

Issue Date: May 18, 1994

Authority: [32 CFR 199.4](#)

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### 1.0 CPT<sup>1</sup> PROCEDURE CODES

19300, 19304, 19318

### 2.0 DESCRIPTION

**2.1** Pathological gynecomastia is an abnormal enlargement of the male mammary glands. Some causes of pathological gynecomastia are testicular or pituitary tumors, some syndromes of male hypogonadism, cirrhosis of the liver, administration of estrogens for prostatic carcinoma, and therapy with steroidal compounds.

**2.2** Physiological (pubertal) gynecomastia occurs in teenage boys, usually between the ages of 13-15. In more than 90% of these boys, the condition resolves within a year. Gynecomastia persisting beyond one year is severe and is usually associated with pain in the breast from distension and fibrous tissue stroma.

### 3.0 POLICY

Benefits may be cost-shared for medically necessary medical, diagnostic, and surgical treatment.

**Note:** Coverage criteria for surgical interventions may include, but is not limited to: severe gynecomastia (enlargement has not resolved after one year); fibrous tissue stroma exists; or breast pain.

### 4.0 EXCLUSION

Surgical treatment performed purely for psychological reasons.

- END -

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## Preauthorization Requirements For Substance Use Disorder Detoxification And Rehabilitation

Issue Date: March 13, 1992

Authority: [32 CFR 199.4\(b\)\(6\)\(iii\)](#) and 10 USC 1079(a)

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### 1.0 BACKGROUND

In the National Defense Authorization Act for Fiscal Year 1991 (NDAA FY 1991), Public Law 101-510 and the Defense Appropriations Act for 1991, Public Law 101-511, Congress addressed the problem of spiraling costs for mental health services under TRICARE. These statutes made two principal changes. First, they established new day limits for inpatient mental health services and secondly, they mandated prior authorization for all nonemergency inpatient mental health admissions, with required certification of emergency admissions within 72 hours.

### 2.0 POLICY

Effective October 1, 1991, preadmission and continued stay authorization is required before services for substance use disorders may be cost-shared. Preadmission and continued stay authorization is required for both detoxification and rehabilitation services. To comply with the statutory requirements and to avoid denial, requests for preadmission authorization on weekends and holidays are discouraged. All admissions for rehabilitation are elective and must be certified as medically/psychologically necessary prior to admission. The admission criteria shall not be considered satisfied unless the patient has been personally evaluated by a physician or other authorized health care professional with admitting privileges to the facility to which the patient is being admitted prior to the admission.

### 3.0 POLICY CONSIDERATIONS

#### 3.1 Treatment of Mental Disorders

In order to qualify for mental health benefits, the patient must be diagnosed by a licensed, qualified mental health professional to be suffering from a mental disorder, according to the criteria listed in the current edition of the **Diagnostic and Statistical Manual of Mental Disorders** (DSM) or a mental health diagnosis in International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) for services provided **on or before September 30, 2014** or International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for services provided on or after **October 1, 2014**. Benefits are limited for certain mental disorders, such as specific developmental disorders. No benefits are payable for "Conditions Not Attributable to a Mental Disorder." In order for treatment of a mental disorder to be medically or psychologically necessary, the patient must, as a result of a diagnosed mental disorder, be experiencing both physical or psychological distress and an impairment in his or her ability to function in appropriate

Preauthorization Requirements For Substance Use Disorder Detoxification And Rehabilitation

occupational, educational or social roles. It is generally the degree to which the patient's ability to function is impaired that determines the level of care (if any) required to treat the patient's condition.

**3.2** Admissions occurring on or after October 1, 1991, to all facilities (includes Diagnosis Related Group (DRG) and non-DRG facilities).

**3.2.1** Detoxification. Stays for detoxification are covered if preauthorized as medically/psychologically necessary. Days of detoxification must be counted toward the statutory day limit which went into effect October 1, 1991, limiting care for adults (age 19 and over) to 30 days in a fiscal year or 30 days in an admission and to 45 days for children (age 18 and under). In determining the medical or psychological necessity of detoxification and rehabilitation for substance use disorder, the evaluation conducted by the contractor shall consider the appropriate level of care for the patient and the intensity of services required by the patient. Emergency and inpatient hospital services are covered when medically necessary for the active medical stabilization, and for treatment of medical complications of substance use disorder. Authorization prior to admission is not required in the case of an emergency requiring an inpatient acute level of care, but authorization for a continuation of services must be obtained promptly. Admissions resulting from a bona fide emergency should be reported within 24 hours of the admission or the next business day after the admission, but must be reported to the contractor within 72 hours of the admission. Emergency and inpatient hospital services are considered medically necessary only when the patient's condition is such that the personnel and facilities of a hospital are required. Stays for detoxification in a substance use disorder facility are limited to seven days unless the limit is waived by the contractor and must be provided under general medical supervision.

**3.2.2** Rehabilitative care. The patient's condition must be such that rehabilitation for substance use disorder must be provided in a hospital or in an organized inpatient substance use disorder treatment program. Rehabilitation stays are covered if preauthorized as medically/psychologically necessary. Coverage during a single benefit period is limited to no more than one inpatient stay (prior to October 1, 2008, exclusive of stays classified in DRG 433; and on or after October 1, 2008, exclusive of stays classified in DRG 894) in hospitals subject to the DRG-based payment system or 21 days in a DRG-exempt facility for rehabilitative care unless the limit is waived by the contractor. Days of rehabilitation must be counted toward the statutory day limit, restricting care for adults (age 19 and over) to 30 days in a fiscal year or 30 days in an admission and to 45 days for children (aged 18 and under). The concept of an emergency admission does not apply to rehabilitative care.

**3.2.3** Waiver of Benefit Limits. The specific benefit limits set forth in this chapter may be waived by the contractor in special cases based on a determination that all of the following are met:

**3.2.3.1** Active treatment has taken place during the period of the benefit limit and substantial progress has been made according to the plan of treatment.

**3.2.3.2** Further progress has been delayed due to the complexity of the illness.

**3.2.3.3** Specific evidence has been presented to explain the factors that interfered with further treatment progress during the period of the benefit limit.

**3.2.3.4** The waiver request includes specific time frames and a specific plan of treatment which will complete the course of treatment.

**3.2.4** The request for preauthorization must be received by the contractor prior to the planned admission. In general, the decision regarding preauthorization shall be made within one business day of receipt of a request for preauthorization, and shall be followed with written confirmation. In the case of an authorization issued after an admission resulting from approval of a request made prior to the admission, the effective date of the certification shall be the date of the receipt of the request. If the request on which the approved authorization is based was made after the admission (and the case was not an emergency admission), the effective date of the authorization shall still be the date of receipt of the request. The contractor may grant an exception to the requirement for preauthorization if the services otherwise would be payable except for the failure to obtain preauthorization.

**3.2.5** Preadmission authorization is required even when the beneficiary has other health insurance because the statutory requirement is applicable to every case in which payment is sought, regardless of whether it is first payer or second payer basis.

### **3.3 Payment Responsibility**

**3.3.1** Any inpatient mental health care obtained without requesting preadmission authorization or rendered in excess of the 30/45 day limit (or beyond the DRG long-stay outlier) without following concurrent review requirements, in which the services are determined excluded by reason of being not medically necessary, is not the responsibility of the patient or the patient's family until:

**3.3.1.1** Receipt of written notification by a contractor that the services are not authorized; or

**3.3.1.2** Signing of a written statement from the provider which specifically identifies the services which will not be reimbursed. The beneficiary must agree, in writing, to personally pay for the non-reimbursable services. General statements, such as those signed at admission, do not qualify.

**3.3.2** If a request for waiver is filed and the waiver is not granted by the contractor benefits will only be allowed for the period of care authorized.

### **3.4 Concurrent Review**

Concurrent review of the necessity for continued stay will be conducted. For care provided under the DRG-based payment system, concurrent review will be conducted only when the care falls under the DRG long-stay outlier. The criteria for concurrent review shall be those set forth in [paragraph 3.2](#). In applying those criteria in the context of concurrent review, special emphasis is placed on evaluating the progress being made in the active clinical treatment being provided and on developing/refining appropriate discharge plans. In general, the decision regarding concurrent review shall be made within one business day of the review, and shall be followed with written confirmation.

**3.5** For purposes of counting day limits, a move from one facility to another facility can be considered a transfer when documentation establishes that coordination for the move existed between two like facilities for the purpose of ensuring continued treatment of the condition requiring the original admission. Under these circumstances, the admission to a new facility would be considered a continuous uninterrupted Episode Of Care (EOC). If the documentation does not

establish that coordination for the move existed between the two facilities, then the intent to transfer cannot be established and the move should be considered a discharge.

#### **4.0 EXCEPTION**

For Dual Eligible beneficiaries, these requirements apply when TRICARE is primary payer. As secondary payer, TRICARE will rely on and not replicate Medicare's determination of medical necessity and appropriateness in all circumstances where Medicare is primary payer. In the event that TRICARE is primary payer for these services and preauthorization was not obtained, the contractor will obtain the necessary information and perform a retrospective review.

- END -

## Chapter 7

## Section 3.17

# Eating Disorders

Issue Date: July 19, 1983

Authority: [32 CFR 199.4\(c\)\(3\)\(ix\)](#)

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### 1.0 DESCRIPTION

The following diagnoses are considered by the current edition of the **Diagnostic and Statistical Manual of Mental Disorders** (DSM) to be eating disorders:

- Anorexia Nervosa
- Bulimia Nervosa
- Feeding and Eating Disorders of Infancy and Early Childhood
  - Pica
  - Rumination Disorder
  - Feeding Disorder of Infancy or Early Childhood
- Eating disorder not otherwise specified

### 2.0 POLICY

**2.1** A claim for treatment of an eating disorder diagnosis is to be adjudicated as a mental health claim.

**2.2** Inpatient and outpatient claims for services and supplies (otherwise authorized) provided within an eating disorder program operated by an authorized institutional provider may not be denied solely on the basis that the services were provided in an eating disorder program.

- END -



## Applied Behavioral Analysis (ABA)

Issue Date: August 10, 2012

Authority: 10 USC 1079(a), Section 705 NDAA FY 2013 Public Law No: 112-239, 32 CFR 199.4(c),  
and 32 CFR 199.6

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### 1.0 CPT<sup>1</sup> PROCEDURE CODES

1181F, 1450F

### 2.0 HCPCS CODE

S5110, S5115, G8539, G8542, G9165 - G9167

### 3.0 DESCRIPTION

**3.1** Under authority of Section 705 of National Defense Authorization Act (NDAA) Fiscal Year (FY) 2013, TRICARE Management Activity (TMA) will cover Applied Behavior Analysis (ABA) for an Autism Spectrum Disorder (ASD) diagnosis in accordance with paragraph 5.2 as a benefit under the TRICARE Basic Program in accordance with applicable TRICARE guidelines. This is an interim benefit under the one year authority of Section 705 NDAA FY 2013 in accordance with Chapter 1, Section 1.3.

**3.2** Behavioral Analyst Certification Board (BACB) defines that ABA has established standards for practice and distinct methods of service by providers with recognized experience and educational requirements for practice. Information regarding the content of ABA is contained in the BACB Behavior Analysis Task List, available at: <http://www.bacb.com/Downloadfiles/AutismTaskList/708AutismTaskListF.pdf>.

### 4.0 DEFINITIONS

**4.1** Applied Behavior Analysis (ABA). According to the BACB Practice Guidelines (2012), ABA is “the design, implementation, and evaluation of environmental modifications to produce socially significant improvement in human behavior. ABA includes the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. ABA uses changes in environmental events, including antecedent stimuli and consequences, to produce practical and significant changes in behavior. Direct observation, measurement and recording of behavior are defining characteristics of ABA” (p. 4). For TRICARE Program purposes, ABA has a component covered as an interim benefit under the TRICARE Basic Program and a reinforcement component covered for Active Duty Family Members (ADFM) under the Extended Care Health Option (ECHO) Enhanced Access to Autism Services Demonstration (Autism Demonstration) and

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under the authority of Section 705 of National Defense Authorization Act (NDAA) Fiscal Year (FY) 2013 authorizing a one year pilot program (ABA Pilot) for Non-Active Duty Family Members (NADFM).

**4.2** ASD Diagnosis. The diagnosis of a condition limited to those conditions listed in [paragraph 5.2](#) by an ASD diagnosing provider listed in [paragraph 5.7](#).

**4.3** ABA Assessment by the Behavior Analyst. A developmentally appropriate assessment process that is used for formulating an individualized ABA Treatment Plan (TP) conducted by a Board Certified Behavior Analyst (BCBA), or Board Certified Behavior Analyst - Doctoral (BCBA-D) or other TRICARE authorized ABA providers practicing within the scope of their state license or state certification. For TRICARE purposes, an ABA assessment includes data obtained from multiple methods to include direct observation and the measurement and recording of beneficiary behavior. A functional assessment that may include a functional analysis (see [paragraph 4.5](#)) shall be required to address problematic behaviors. Data gathered from parent/caregiver interview and parent report rating scales is also required. The ABA assessment by the BCBA, BCBA-D, or other TRICARE authorized ABA providers practicing within the scope of their state license or state certification is required prior to starting ABA under the TRICARE Basic Program and is also a prerequisite for all ABA reinforcement under the Autism Demonstration and the ABA Pilot.

**4.4** Standardized Psychometric Testing. Standardized psychometric tests are measures developed by the social sciences that have been researched to ensure validity and reliability. A reliable measure is one that measures a construct consistently across time, individuals, and situations. A valid measure is one that measures what it is intended to measure. Reliability is necessary, but not sufficient, for validity. For TRICARE purposes, per [paragraph 5.8.3](#), specific standardized psychometric tests are required to be administered by a qualified clinician in order to establish baseline measurement of the impairments of an ASD prior to the start of all ABA. This requirement applies to all ABA provided by the BCBA, BCBA-D, or other TRICARE authorized ABA providers practicing within the scope of their state license or state certification under the TRICARE Basic Program and all ABA reinforcement under the Autism Demonstration or the ABA Pilot. Repeat testing is required at specified intervals per [paragraph 5.8.5](#) for all beneficiaries receiving ABA under the TRICARE Basic Program and for all ABA reinforcement under the Autism Demonstration or the ABA Pilot.

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

**4.6** ABA Treatment Plan (TP). A written document outlining the ABA plan of care for the individual, including the expected progression of ABA. For TRICARE purposes, the ABA TP consists of an "initial ABA Treatment Plan" based on the initial ABA assessment and the "ABA Treatment Plan Update" that is the revised and updated ABA TP based on periodic reassessment of beneficiary progress toward the objectives and goals. Components of the ABA TP include: the identified behavioral targets for improvement, the ABA specialized interventions to achieve improvement, ABA TP objectives, and the ABA TP short and long-term goals that are defined below.

**4.7** ABA Specialized Interventions. ABA specialized interventions are ABA methods designed to improve the functioning of a specific ASD target deficit in a core area affected by the ASD such as social interaction, communication or behavior. The ABA provider delivers ABA to the beneficiary through direct administration of the ABA specialized interventions during one to one (i.e., face to face) interactions.

**4.8** ABA Treatment Plan Objectives. ABA TP objectives are the short, simple, measurable steps that must be accomplished in order to reach the short-term and long-term goals of ABA.

**4.9** ABA Treatment Plan Goals. These are the broad spectrum, complex short-term and long-term desired outcomes of ABA.

**4.10** ABA includes: an initial ABA assessment, the initial ABA TP, the delivery of ABA specialized interventions delivered by the BCBA or BCBA-D, TRICARE eligible parent/caregiver ABA training, repeat ABA assessments, and ABA TP updates. ABA reinforcement provided by Board Certified Assistant Behavior Analyst (BCaBA) and ABA Tutors are not covered as a benefit under this section.

**4.11** Referral and Supervision. "Referral and supervision" means that the TRICARE authorized provider who refers the beneficiary for ABA must actually see the beneficiary to evaluate the qualifying ASD condition to be treated prior to referring the beneficiary for ABA; the referring provider also provides ongoing oversight of the course of referral-related ABA throughout the period during which the beneficiary is receiving ABA in response to the referral. Only those providers listed under [paragraph 5.7.1](#) may refer beneficiaries for ABA in accordance with [paragraph 5.8.1](#).

## **5.0 POLICY**

**5.1** TRICARE covers ABA for eligible ADFMs and NADFM with a diagnosis of any of the five listed diagnoses of a Pervasive Developmental Disorder (PDD), also known as ASD, defined in [paragraph 5.2](#) as a TRICARE Basic Program benefit. ABA reinforcement is covered separately for ADFMs under the Autism Demonstration and NADFM under the ABA Pilot.

**5.2** For services provided on or before September 30, 2014, the covered **International Classification of Diseases, Ninth Edition (ICD-9)** ASD diagnoses are described under the PDD category of the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Presently, a covered diagnosis of ASD includes PDDs and their associated DSM, Fourth Edition, Text Revision, (DSM-IV-TR) diagnostic code: Autistic Disorder (299.00), Rett's Disorder (330.8), Childhood Disintegrative Disorder (CDD) (299.10), Asperger's Disorder (299.80), and Pervasive Development Disorder Not Otherwise Specified (PDD-NOS) (including Atypical Autism) (299.80). These five DSM-IV-TR diagnostic codes have corresponding codes in the currently used edition of the International Classification of Diseases, Clinical Modification manual (currently ICD-9-CM). The ICD-9-CM codes for the five ASDs are: Autistic Disorder (299.0), Rett's Syndrome (330.8) (found under "Other Specific Cerebral Degenerations"), CDD (299.1), Asperger's Disorder (299.8), and PDD-NOS (to include Atypical Autism) (299.9).

**Note:** The DSM-V was released in May 2013. Military Health System (MHS) implementation of the DSM-V will be coordinated within DoD and announced in future policy revisions. [Paragraphs 5.1](#) and [5.2](#) of this policy will be revised in accordance with those events.

**5.3** For services provided on or after October 1, 2014, the covered International Classification of Diseases, Tenth Edition (ICD-10) ASD diagnoses are: Autistic Disorder (F84.0), Rett's Disorder (F84.2), CDD (F84.3), Asperger's Disorder (F84.5), and PDD-NOS (including Atypical Autism) (F84.9). These five DSM-IV-TR diagnostic codes are converted to corresponding codes in the currently used edition of the International Classification of Diseases, Clinical Modification manual (currently ICD-10-CM) as part of the claims process under TRICARE. The ICD-10-CM codes for the five ASDs are: Autistic Disorder (F84.0), Rett's Syndrome (F84.2) (found under "Other Specific Cerebral Degenerations"), CDD (F84.3), Asperger's Disorder (F84.5), and PDD-NOS (to include Atypical Autism) (F84.9).

**5.4** ABA under the TRICARE Basic Program refers to ABA provided one-to-one, in person to the beneficiary by TRICARE authorized ABA providers (described in paragraphs 5.5 and 5.9) to improve social interaction, communication and behavior as related to the core deficits and symptoms of an ASD. ABA reinforcement provided by BCaBAs and ABA tutors is covered separately under the Autism Demonstration for ADFMs and the ABA Pilot for NADFMs.

**5.5** ABA is a specialized intervention administered by an authorized provider described in paragraph 5.9 who is a professional with advanced formal training in behavioral analysis, to include at least a master's degree and several hundred hours of graduate level instruction or mentored or supervised experience with another BCBA. The only providers qualified to deliver ABA under the TRICARE Basic Program are masters-level BCBA or BCBA-Ds certified by the BACB or other TRICARE authorized ABA providers practicing within the scope of their state license or state certification. In accordance with qualifications of other TRICARE-authorized individual providers of behavioral health care (see 32 CFR 199.6(c)(2)), these providers possess the education, required experience and supervision, and scope of practice consistent with TRICARE Basic Program regulations. Qualifications for individuals providing ABA reinforcement are set forth in the TRICARE Operations Manual (TOM) sections on the Autism Demonstration and the ABA Pilot.

**5.6** The TRICARE Basic Program shall serve as the single entry point for all TRICARE eligible beneficiaries referred for ABA under the TRICARE Basic Program and ABA reinforcement covered separately under the Autism Demonstration and ABA Pilot. This includes all ADFMs and NADFMs.

### **5.7 ASD Diagnosing Providers**

**5.7.1** Diagnosis of ASD shall be rendered by a TRICARE-authorized physician Primary Care Managers (P-PCM) or by a specialized ASD provider:

**5.7.1.1** For the purposes of the diagnosis of ASD, TRICARE authorized P-PCMs include: TRICARE authorized family practice, internal medicine and pediatric physicians whether they work in the purchased care or direct care system. In cases where the beneficiary does not have a P-PCM (as is sometimes the case for beneficiaries with TRICARE Prime Remote), the diagnosis may be rendered by a TRICARE authorized physician in any of the disciplines described above under P-PCM, or by a TRICARE authorized specialty ASD provider as described in paragraph 5.7.1.2.

**5.7.1.2** Authorized specialty ASD providers include: TRICARE authorized physicians board-certified or board-eligible in behavioral developmental pediatrics, neurodevelopmental pediatrics, pediatric neurology or child psychiatry; or Ph.D. or Psy.D. licensed clinical psychologists.

**5.7.2** Other PCMs, including a Nurse Practitioner (NP) and a Physician Assistant (PA) or other providers not having the qualifications described in [paragraph 5.7.1](#), are not ASD diagnosing providers for TRICARE coverage purposes.

## **5.8 Referring Providers, Referrals and Prior Authorization**

**5.8.1** Both ABA assessment and ABA under the TRICARE Basic Program, and any ABA reinforcement otherwise authorized under the Autism Demonstration for ADFMs or the ABA Pilot for NADFM require: (a) a referral by a provider listed under [paragraph 5.7.1](#) who is authorized to diagnose an ASD and refer to specialty care, and (b) authorization by the appropriate Managed Care Support Contractor (MCSC) prior to either initiation of the ABA assessment or beginning ABA (see the TOM, [Chapter 8, Section 5](#), TOM, [Chapter 7, Section 2](#), and the [Chapter 1, Section 7.1](#) for details concerning referrals and authorization requirements). Referral for ABA assessment will precede referral for ABA which is contingent upon the results of the ABA assessment. Each authorization period for ABA shall be for one year. A new referral is required for each period of authorized care (see the TOM, [Chapter 8, Section 5](#)).

**5.8.2** Other PCMs, including a NP and a PA or other providers not having the qualifications described in [paragraph 5.7.1](#), may not refer beneficiaries for ABA assessment or ABA for TRICARE coverage purposes.

**5.8.3** Authorization of ABA first requires a referral for a comprehensive ABA assessment by a BCBA, BCBA-D, or other TRICARE authorized ABA providers practicing within the scope of their state license or state certification. In addition to the essential ABA assessment elements recommended in the Guidelines of the BACB, the ABA assessment will include baseline psychometric testing using standardized assessment measures. The required baseline psychometrics that must be included as part of the initial ABA assessment are:

- Autism Diagnostic Observations Scale, Second Editions (ADOS-2) (Lord, C., et.al., 2012); and,
- Vineland Behavioral Scale II (VBS-II) (Sparrows, 2005) to include the Maladaptive Behavior Scale.

If the ABA provider conducting the initial ABA assessment is not qualified to administer these standardized assessment measures, then the TRICARE authorized referring provider must refer the beneficiary to a TRICARE authorized provider who possesses the requisite training (e.g., a licensed clinical psychologist) to provide this psychometric testing to establish baseline impairment across the core domains impacted by the ASD. Alternatively, the TRICARE authorized referring provider may administer the standardized psychometric assessment measures listed above, but only if qualified. Regardless of which qualified provider conducts the required standardized testing, it is the responsibility of the ABA provider conducting the ABA assessment to ensure that the results of the required testing are incorporated into the initial ABA assessment.

**5.8.4** Based on the results of the initial ABA assessment, the referring provider will submit a referral to the MCSC for authorization for ABA for one year, if indicated, and a new referral for reauthorization annually. The referral must contain:

- The ASD diagnosis rendered by a TRICARE authorized ASD diagnosing provider and

confirmed by the ABA assessment and standardized testing.

- A description of why ABA is appropriate (“appropriate care” is defined for the purposes of ABA coverage under TRICARE in [paragraph 5.10](#)). The description shall include:
  - The functional impairments and the degree of impairment in each domain (social interaction, communication, behavior);
  - A description of how ABA is expected to improve each domain affected by the ASD (social interaction, communication and behavior);
  - An assessment of each TRICARE eligible family member/caregiver’s ability to reinforce ABA interventions at home;
  - A brief summary of the baseline psychometric testing results. The repeat psychometric testing must show progress consistent with the progress reported on the ABA TP update by the BCBA, BCBA-D, or other TRICARE authorized ABA provider practicing within the scope of his/her state license or state certification. A brief summary of this information shall be included in the referral for continued ABA; and
  - A recommendation for the number of weekly hours of ABA under the TRICARE Basic Program and the number of weekly hours of ABA reinforcement under either the Autism Demonstration or the ABA Pilot shall be included in the referral.

If the results of the ABA assessment indicate the beneficiary does not meet current criteria for diagnosis of an ASD, then a course of ABA is not authorized and the beneficiary should not be referred for ABA.

**5.8.5** Repeat standardized psychometric testing utilizing the Vineland II (to include the Maladaptive Behavior Scale) is required every 180 days to assess progress as noted in [paragraph 5.8.3](#). This follow-up testing will require a referral to a qualified TRICARE authorized provider to administer the test unless the referring provider or the ABA provider is qualified to administer the Vineland II. The results of all testing shall be included in each reauthorization referral for ABA. Objective progress on the required standardized psychometric test is required for continued authorization.

**5.8.6** The TRICARE authorized provider qualified to conduct the standardized psychometric testing will submit the baseline and every 180 day psychometric testing report to the referring provider (unless the testing provider is also the referring provider) and the MCSC.

**Note:** BCBA, BCBA-Ds or other TRICARE authorized ABA providers practicing within the scope of their state license or state certification may not necessarily be trained in administration of the ADOS-II or VBS-II, therefore formal psychometric testing at baseline and every 180 days may need to be administered by qualified professionals (i.e., clinical psychologists) who possess the requisite training to administer the required measures.

**5.8.7** The MCSC reviewer shall review all ABA referral documentation for appropriateness of care. MCSC review is not required for the TRICARE Overseas Program (TOP); see [paragraph 5.12](#) for details. However, the TOP will review the referrals to ensure the baseline and 180 day repeat psychometric testing were completed and the testing results summary support ABA.

**5.8.8** The BCBA, BCBA-D, or other TRICARE authorized ABA provider practicing within the scope of his/her state license or state certification shall provide the MCSC with the ABA TP updates during the month prior to reauthorization being due.

**5.8.9** The MCSC shall provide (via fax or other appropriate means) the referring provider a copy of the initial ABA TP and all ABA TP updates.

**5.8.10** These requirements apply to all ABA provided under the TRICARE Basic Program (i.e. TRICARE Prime, TRICARE Prime Remote, Standard, Extra, TRICARE Reserve Select, TRICARE Retired Reserve, TRICARE for Life) and any additional ABA reinforcement under the Autism Demonstration as well as ABA reinforcement under the ABA Pilot, except overseas as discussed in [paragraph 5.12.1](#). ABA shall appear on the "Requires Prior Authorization" list under TRICARE Standard.

## **5.9 ABA Providers**

**5.9.1** For ABA provided under the TRICARE Basic Program, the following individuals who otherwise meet all applicable requirements of TRICARE-authorized providers under the TRICARE Basic Program are TRICARE-authorized ABA providers when referred by and working under the referral and supervision of the referring providers as set forth in [paragraph 9.0](#) of this policy:

**5.9.1.1** Have a master's degree or above in a qualifying field as defined by the BACB;

**5.9.1.2** Have a current State license as an Applied Behavior Analyst to provide ABA in those states providing state licensure;

**5.9.1.3** Are currently State-certified as an Applied Behavioral Analyst qualified to practice at the full clinical level; able to conduct an ABA assessment and develop the initial ABA TP and ABA TP updates independently for all complexity of cases; or

**5.9.1.4** Where such State license or certification is not available, are certified by the BACB as a BCBA or BCBA-D.

**5.9.1.5** The Applied Behavior Analyst (unless the Applied Behavior Analyst is also a licensed clinical psychologist) must work under the referral and supervision of the referring P-PCM or specialized ASD provider as defined in [paragraph 5.7.1](#).

**Note:** Individuals certified by the BACB as a BCaBA or ABA Tutors are not TRICARE-authorized ABA providers under the TRICARE Basic Program.

## **5.10 Appropriate Care Requirements For ABA Authorization**

**5.10.1** Before the MCSC can approve a referral for ABA for an ASD, the referral and ABA TP must demonstrate that appropriate care standards are met. Appropriate care for ASDs implies the reasonable expectation that ABA shall result in measurable improvement in each of the ABA

targeted areas of impairment identified in the ABA TP. ABA TP updates by baseline and every 180 day psychometric testing as described in [paragraph 5.14.1.5](#).

**5.10.1.1** The degree of impairment(s) in social interaction, communication and behavior must present at a level that:

- Presents a health or safety risk to self or others (e.g., severely disruptive behaviors, repetitive/stereotyped behaviors, aggression toward others); OR,
- Significantly interferes with home or community activities as measured by the appropriate assessment tools and psychometrics. See [paragraphs 5.14.1.3, 5.14.1.4, and 5.8.5](#).

**5.10.1.2** The beneficiary must be able to actively participate in ABA as observed by the BCBA, BCBA-D, or other TRICARE authorized ABA provider practicing within the scope of his/her state license or state certification during the ABA assessment.

### **5.11 Payable ABA Provided By ABA Providers**

**5.11.1** Once the diagnosis of an ASD has been made by an ASD diagnosing provider in a child 18 months or older in accordance with [paragraph 5.7](#), the payable ABA provided by the BCBA, BCBA-D, or other TRICARE authorized ABA provider practicing within the scope of his/her state license or state certification include:

- Initial ABA assessment performed one-to-one, in person;
- Development of the initial ABA TP;
- Delivery of ABA TPs specialized interventions delivered by the BCBA, BCBA-D, or other TRICARE authorized ABA provider practicing within the scope of his/her state license or state certification;
- Follow up monitoring and repeat ABA assessment; and
- ABA TP updates.

The initial ABA assessment and initial ABA TP process consists of a developing a written assessment of the objectives and goals of behavior modification of specific problematic behavioral targets and specific evidenced-based practices and techniques to be utilized by a BCBA, BCBA-D, or other TRICARE authorized ABA provider practicing within the scope of his/her state license or state certification.

**5.11.2** Providing ABA specialized interventions with the TRICARE eligible beneficiary as well as training of TRICARE eligible family member/caregivers to provide ABA reinforcement in accordance with the ABA TP; and

**5.11.3** Monitoring of the beneficiary's progress toward ABA TP objectives and goals specified in the initial ABA TP through annual ABA TP updates by the BCBA, BCBA-D, or other TRICARE authorized ABA provider practicing within the scope of his/her state license or state certification.

The updated ABA TP must reflect new or modified objectives and goals, with strategies based on the individual needs of the patient.

**Note:** ABA reinforcement provided under the Autism Demonstration for ADFMs is not a covered benefit under the TRICARE Basic Program and cannot be billed under the TRICARE Basic Program (see the TOM, [Chapter 18, Section 8](#)). This is also true for ABA reinforcement provided to NADFM's under the ABA Pilot.

## **5.12 ABA Provided Under the TOP**

**5.12.1** ABA can only be authorized under the TRICARE Overseas Program (TOP) for ABA provided by either a BCBA or BCBA-D in countries that have BCBA and BCBA-Ds certified by the BACB.

**5.12.2** The TOP contractor shall be responsible for verifying compliance with all requirements in [paragraph 5.7](#) (Diagnosis) and [5.11](#) (Payable Services). In addition, the TOP contractor shall be responsible for requirements identified in [paragraphs 5.8.1](#) through [5.8.8](#) (Referring Providers, Referral and Prior Authorization). Note that [paragraph 5.8.8](#) specifies that "MCSC review for medical necessity and appropriate care determination is not required for the TOP. The TOP contractor shall consider that a referral from a provider identified in [paragraphs 5.7.1](#) and [5.9](#) for ABA is "appropriate care" provided that the psychometric testing has been completed and that testing results support initiation or continuation of ABA.

**5.12.3** European and other international providers certified by the BACB as a BCBA or BCBA-D are eligible to become TRICARE authorized providers of ABA for the overseas program.

**5.12.4** In situations where there are no BCBA's or BCBA-Ds certified by the BACB within the TRICARE specialty care access standards in the host nation, there is no ABA benefit under the TRICARE Basic Program.

**5.12.5** Reimbursement of TOP beneficiary claims for ABA obtained overseas shall be based upon the lesser of billed charges, the negotiated reimbursement rate, or the government-directed reimbursement rate foreign fee schedule. (See the TOM, [Chapter 24, Section 9](#) and the TRICARE Reimbursement Manual (TRM), [Chapter 1, Section 35](#) for additional guidance).

## **5.13 ABA Assessments And ABA TPs**

The initial ABA assessment, the initial ABA TP, the repeat ABA assessment and ABA TP updates shall be completed by the BCBA, BCBA-D, or other TRICARE authorized ABA provider practicing within the scope of his/her state license or state certification under the TRICARE Basic Program for all TRICARE beneficiaries receiving ABA. ADFMs are eligible for additional ABA reinforcement under Autism Demonstration under ECHO (see the TOM, [Chapter 18, Section 8](#) for details). Non Active Family Members (NADFM's) are eligible for additional ABA reinforcement under the ABA Pilot in accordance with the requirements of NDAA FY 2013, Section 705 for the duration of the one year pilot period under Public Law No: 112-239.

## **5.14 ABA Documentation of ABA Assessment(s), Initial ABA TP and TP Updates**

**5.14.1** The initial TP shall include:

**5.14.1.1** The beneficiary's name, date of birth, date the initial ABA assessment and initial ABA TP was completed, the sponsor's Department of Defense (DoD) Benefit Number or other patient identifiers, name of the referring provider, background and history, objectives and goals, TRICARE eligible family member/caregiver training and ABA recommendations. The ABA assessment shall include documentation of the specific problematic behavioral targets and the corresponding specific ABA intervention to treat each target.

**5.14.1.2** Background and history shall include information that clearly demonstrates the beneficiary's condition, diagnoses, medical comorbidities and family history, how long the beneficiary has been receiving ABA.

**5.14.1.3** A summary of baseline ASD psychometric testing findings on the ADOS-2 and the Vineland II (in accordance with [paragraph 5.4](#)).

**Note:** The core deficits identified on psychometric testing should be consistent with the deficits identified by the BCBA, BCBA-D, or other TRICARE authorized ABA provider practicing within the scope of his/her state license or state certification on the initial ABA assessment. The TP objectives and goals should address each deficit.

**5.14.1.4** ABA objectives and goals shall include a detailed description of the targeted skills and behaviors that shall be addressed through specific ABA interventions for each target and the objectives that shall be measured. Objectives and goals are individualized based on beneficiary need and address identified deficits in each of the following domains:

- Social interaction
- Communication
- Behavior

**5.14.1.5** TRICARE eligible family member/caregiver training shall be included in the initial ABA TP. TRICARE eligible family member/caregiver training shall be provided as a separate billable ABA service under the TRICARE Basic Program. The initial ABA TP shall include a detailed plan that specifies how TRICARE eligible family member/caregivers shall be trained to implement and reinforce skills and behaviors within a variety of settings.

**5.14.1.6** The initial ABA TP shall include a summary of the expected extent that TRICARE eligible family member/caregivers shall be able to implement ABA interventions with the beneficiary in support of the ABA TP. The ABA TP Update will include an annual reassessment of how well the TRICARE eligible family member/caregivers were consistently able to implement ABA interventions with the beneficiary.

**5.14.1.7** Annual repeat ABA assessment shall evaluate progress for each ABA intervention associated with each specific behavioral target identified on the initial ABA TP and the ABA TP updates. Documentation on the initial ABA TP shall also include the BCBA or BCBA-D recommendation for the number of weekly hours of ABA under the TRICARE Basic Program and the recommended number of weekly hours for ABA reinforcement by ABA Tutors or BCaBAs under Autism Demonstration for ADFMs or the ABA Pilot for NADFM.

**5.14.1.8** Annual repeat ABA reassessment and TP updates shall document the evaluation of progress for each behavior target identified on the initial ABA TP and prior TP updates. Documentation of the annual ABA reassessment and TP update shall include:

- Date and time of the annual reassessment/TP update was done;
- Signature of the ABA provider conducting the reassessment/TP update;
- Evaluation of progress toward each behavioral target's objectives and goals;
- Revisions to the TP to include identification of new behavioral targets, objectives and goals;
- Report of the results of the most recent Vineland II psychometric testing; and
- Recommendation for continued ABA to include a recommendation for:
  - The number of weekly hours of ABA under the TRICARE Basic Program;
  - The number of weekly hours of ABA reinforcement under either the Autism Demonstration or the ABA Pilot; and
  - A projected duration of ABA.

### **5.15 Authorization for Continued ABA**

Authorization is based on continued appropriate care as measured by the required repeat ABA assessment documented on the ABA TP updates, the psychometric testing reports and on documentation on the referral in accordance with [paragraphs 5.7, 5.8, and 5.14.1.4](#) of this policy. The MCSC reviews the BCBA, BCBA-D's or other TRICARE authorized ABA provider's ABA TP updates, the psychometric testing reports and the referral documentation to determine whether the requirements for continued clinical appropriateness are met. Special attention shall be paid to ensuring that the BCBA/BCBA-D, or other TRICARE authorized ABA provider's ABA TP updates and the psychometric testing reports concur regarding descriptions of beneficiary progress. If these conditions are met, the MCSC may reauthorize ABA for the specified time period as defined in [paragraph 5.8.5](#).

### **5.16 ABA Discharge Criteria**

**5.16.1** The following discharge criteria are established to determine if/when ABA is no longer appropriate:

**5.16.1.1** No measurable progress on psychometric testing has been made toward meeting goals identified on the ABA TP as defined by lack of improvement on the appropriate psychometric defined as in [paragraphs 5.8.3 and 5.8.4](#).

**5.16.1.2** ABA TP gains are determined not to be generalizable or durable over time and do not transfer to the larger community setting (to include school).

**5.16.1.3** The patient or family member/caregiver can no longer participate in ABA.

**5.16.1.4** The patient has met ABA TP goals and is no longer in need of ABA.

**5.16.1.5** Loss of eligibility for TRICARE benefits as defined in [32 CFR 199.3](#).

## **5.17 ABA Benefit Hours**

**5.17.1** The appropriate number of ABA hours shall be authorized based on the individual beneficiary appropriate care needs.

**5.17.2** ABA shall be authorized for a period of one year at a time.

**5.17.3** ABA hour and duration limits shall be set forth in the referral in accordance with the following:

**5.17.3.1** An appropriate number of hours of ABA may be approved by the contractor not to exceed 20 hours a week under the TRICARE Basic Program. Additional ABA hours must be approved by the MCSC medical director under the waiver process. A second year of ABA may be authorized by the contractor based on sufficient documentation for those beneficiaries age 16 and younger. All other requests for additional ABA must be requested through the waiver process and approved by the MCSC medical director as outlined in [paragraph 5.17.4](#).

**5.17.3.2** An appropriate number of hours of ABA reinforcement may be approved by the contractor. For ADFMs or NADFM's receiving additional ABA reinforcement services under the Autism Demonstration or the ABA Pilot respectively, the number of hours authorized under those programs shall be added to the number of weekly hours authorized under the TRICARE Basic Program to determine the total number of weekly hours authorized. Total ABA hours cannot exceed 40 hours a week.

**5.17.4** Waiver of the hourly limits or duration of ABA limits: The specific benefit limitations set forth in this section may be waived by the contractor based on a determination that all of the following criteria are met. The criteria are:

**5.17.4.1** ABA has been delivered for at least one year (for waiver requests for additional hours), or when ABA duration limits have been reached (for waiver requests for additional ABA duration).

Supporting documentation includes:

- Documentation that progress has been insufficient due to the complexity of the ASD needs, and that more hours or a longer duration of ABA are justified to achieve ABA TP objectives and goals;
- A proposed ABA TP that identifies clear, realistic objectives and goals that the referring provider is optimistic can reasonably be achieved with the additional ABA;
- Justification specifying precisely how the additional hours or extended duration of ABA shall be used to achieve the ABA objectives and TP goals;
- Explicit documentation of TRICARE eligible family member/caregiver full

engagement and ability to consistently implement the ABA TP specialized interventions in home/community settings; and,

- The number of ABA hours and the number of ABA reinforcement hours per week, or the specific identified time frame for extended duration of ABA must be identified in the TP.
- In cases of additional duration waiver request, a repeat ADOS-2 must be administered. The ADOS-2 report must support continued medical necessity.

**5.17.4.2** Waiver requests that exceed a total of forty hours of ABA and ABA reinforcement under the Autism Demonstration or ABA Pilot per week in any combination may not be approved.

## **6.0 ABA COPAYMENTS AND REIMBURSEMENT**

**6.1** Claims for ABA under the TRICARE Basic Program shall be submitted by an authorized TRICARE provider on Centers for Medicare and Medicaid Services (CMS) 1500 (08/05): For TOP, the contractor shall work with the TOP Program Office to identify the most appropriate claim form to use depending on the host nation country and the overseas provider's willingness to use the CMS 1500.

**6.2** The following codes have been adopted for non-standardized usage for ABA provided by the BCBA, BCBA-D, or other TRICARE authorized ABA providers practicing within the scope of their state license or state certification under the TRICARE Basic Program. These codes apply for provision of ABA in all authorized settings (the office, home or community setting).

**6.3** Initial ABA assessment with initial ABA TP. The initial ABA assessment with development of the initial ABA TP shall be coded using Current Procedural Terminology<sup>2</sup> (CPT) procedure code 1181F meaning "Initial ABA assessment to determine appropriate indication for ABA."

**6.3.1** Initial ABA assessment with determination of appropriate indication with initial ABA TP. The following three **G** codes must be used in conjunction with CPT<sup>2</sup> procedure code 1181F for billing purposes when the initial ABA assessment concludes that ABA is appropriate and that an initial ABA TP with ABA TP goal(s) is developed:

- G 8539 - code for the initial ABA assessment and initial ABA TP development per 15 minute units of time
- G9165 - the current patient status code
- G9166 - the initial ABA TP goal code

**Note:** Use of three **G** codes (HCPCS codes G8539, G9165, and G9166) for one encounter follows CMS 2013 coding guidance for billing for services such as occupational therapy and physical therapy. Guidance is for these claims to be submitted on the CMS 1500, therefore, unlike electronic billing, standard use of codes is not required.

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**6.3.2** In the event that the initial ABA assessment concludes that ABA is not appropriate for the beneficiary, the BCBA, BCBA-D, or other TRICARE authorized ABA provider practicing within the scope of his/her state license or state certification will code CPT<sup>2</sup> procedure code 1181F meaning "Initial assessment to determine appropriate indication for ABA" and HCPCS code G8542 meaning "No deficiencies identified for which ABA would provide medical benefit, care plan not required per 15 minutes" thus indicating that ABA is not appropriate.

**6.4** ABA rendered by a TRICARE authorized ABA provider, in-person, for TRICARE eligible family member/caregiver ABA training shall be billed using HCPCS code S5110 meaning "TRICARE eligible family member/caregiver training." ABA training may only be provided to a TRICARE eligible family member/caregiver.

**6.5** HCPCS code S5115 meaning "Beneficiary ABA by a TRICARE authorized provider" shall be used for ABA provided directly to the beneficiary receiving ABA by a TRICARE authorized ABA provider listed in [paragraph 5.9](#) regardless of the setting where the ABA is provided.

**6.6** ABA repeat assessment and ABA TP Updates: ABA repeat assessments to determine beneficiary's progress and development of the ABA TP update prior to each reauthorization period shall be coded using CPT<sup>3</sup> code 1450F meaning "Reassessment of symptoms for possible ABA. The three **G** codes identified below must be used in conjunction with CPT<sup>3</sup> procedure code 1450F for claims processing/billing purposes:

- G8539 - ABA repeat assessment and ABA TP update (same code used for initial ABA assessment and initial ABA TP) per 15 minute units of time
- G9165 - current patient status code (same code as required during the initial assessment and initial ABA TP development)
- G9166 - ABA TP goal update code (the same code is used for initial ABA TP goal)

**Note:** Use of the three **G** codes (HCPCS codes G8539, G9165, and G9166) for one encounter follows CMS 2013 coding guidance for billing for services such as occupational therapy and physical therapy.

**6.7** Discharge from ABA: If upon BCBA, BCBA-D, or other TRICARE authorized ABA provider repeat assessment, it is determined that the beneficiary is to be discharged from ABA, CPT<sup>3</sup> procedure code 1450F is to be used in conjunction with the two following **G** codes:

- G8542- continued ABA is not indicated
- G9167- discharge from ABA

**6.8** Reimbursement of claims shall be the lesser of:

**6.8.1** The CHAMPUS Maximum Allowable Charge (CMAC); that is the CHAMPUS national pricing system built on established CPT/HCPCS codes and based on Medicare or TRICARE claims data (at this time there are no CPT/HCPCS codes or CMAC rates for ABA);

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- 6.8.2** The prevailing local market rate;
  - 6.8.3** One hundred and twenty-five dollars (\$125) per hour for ABA specified in [paragraph 5.11](#) provided by the TRICARE authorized ABA provider listed in [paragraph 5.9](#); or
  - 6.8.4** The negotiated rate; or
  - 6.8.5** The billed charge.
- 6.9** ABA is a specialty service under the TRICARE Basic Program requiring a specialty referral; therefore, specialty care cost-shares apply.

ABA is an outpatient service however ABA is not “an outpatient behavioral health” service, therefore outpatient behavioral health benefit rules do not apply. ABA is not subject to the two visits per week limit that applies to outpatient behavioral health visits. ABA is comprised of specialized interventions per [paragraph 4.3](#) provided up to several hours a day and up to five days (Monday - Friday) a week.

**6.10** BCBA, BCBA-D, or other TRICARE authorized ABA provider supervision of BCaBAs and ABA Tutors to include discussions of the ABA TPs, progress, and follow-up ABA assessments shall be billed under the Autism Demonstration or ABA Pilot.

**6.11** The MCSCs shall ensure all TRICARE Encounter Data (TED) requirements outlined in the TRICARE Systems Manual (TSM), [Chapter 2](#) are met including appropriate use of Special Processing Code “BA Applied Behavior Analysis (ABA) (Interim Benefit)”.

## **7.0 EXCLUSIONS**

**7.1** The following exclusions apply to provision of ABA under the TRICARE Basic Program:

- 7.1.1** ABA provided in a group format.
- 7.1.2** ABA rendered by a TRICARE authorized provider type other than those authorized to provide ABA under this Chapter.
- 7.1.3** ABA rendered by an ABA provider not authorized and certified under TRICARE.
- 7.1.4** ABA for all other diagnoses that are not an ASD/PDD.
- 7.1.5** Educational and vocational rehabilitation services.
- 7.1.6** Respite care.
- 7.1.7** ABA not provided one-to-one, in person by the TRICARE authorized BCBA or BCBA-D.
- 7.1.8** ABA provided through remote means; for example through telemedicine/telehealth.
- 7.1.9** ABA provided when there is no ASD diagnosis rendered by a TRICARE authorized ASD diagnosing provider as specified in [paragraph 5.7](#).

**7.1.10** ABA provided when there is no ABA referral from a TRICARE authorized ASD referring provider as specified in [paragraph 5.8](#).

**7.1.11** ABA provided by a BCBA, BCBA-D, or other TRICARE authorized ABA provider (unless the ABA provider is a licensed clinical psychologist) when there is no supervision by the TRICARE authorized ASD referring provider as required in [paragraph 9.0](#) of this policy.

**7.1.12** ABA provided when there is no baseline and 180 day interval follow-up psychometric testing.

**7.1.13** ABA involving aversive techniques or rewards that can be construed as abuse.

## **8.0 CREDENTIALING OF APPLIED BEHAVIOR ANALYSTS**

**8.1** Master's degree or above BCBAs or BCBA-Ds and other ABA providers practicing within the scope of their state license or state certification meeting the requirements for TRICARE Basic Program providers are encouraged to become a TRICARE network provider. Requirements for credentials review for network providers apply. Master's degree or above BCBAs or BCBA-Ds and other ABA providers practicing within the scope of their state license or state certification who do not wish to become part of the TRICARE network may become TRICARE authorized non-network providers. These non-network BCBAs or BCBA-Ds and other TRICARE authorized ABA providers practicing within the scope of their state license or state certification shall undergo a modified credentials review process that shall include review of state licensure or state certification status (if applicable), a review BCBA board certification by the BACB, if applicable a check of BACB complaints section of the BACB web site or a review for complaints to state license or certification boards, if applicable, and a criminal history review (see the TOM, [Chapter 4, Section 1](#)). The credentials of the non-network BCBAs or BCBA-Ds and other TRICARE authorized ABA providers practicing within the scope of their state license or state certification shall be reviewed every three years to ensure that credentials are still valid and that no adverse actions have been taken by the BACB or applicable practice jurisdiction against the BCBA, BCBA-D, or other TRICARE authorized ABA providers practicing within the scope of their state license or state certification.

**8.2** All claims submitted by the BCBA, BCBA-D, or other TRICARE authorized ABA providers practicing within the scope of their state license or state certification for ABA shall use the HIPAA taxonomy (provider code) 103K00000X, Behavior Analyst.

## **9.0 REFERRAL AND SUPERVISION OF APPLIED BEHAVIOR ANALYSTS**

**9.1** The referring P-PCM or specialized ASD provider as defined in [paragraphs 5.7](#) and [5.8](#) is required to provide referral and supervision of the BCBA ABA (unless the BCBA-D is a licensed clinical psychologist).

**9.1.1** Referral and supervision (see [paragraph 4.6](#)) means that the referring provider shall actually see the beneficiary to evaluate the qualifying ASD condition prior to referring the beneficiary to the BCBA, BCBA-D, or other TRICARE authorized ABA provider practicing within the scope of his/her state license or state certification, and that the referring provider provides ongoing oversight of the course of referral-related ABA throughout the period that the beneficiary is receiving ABA in response to the referral.

**9.1.2** The referring provider is not required to be physically located on the premises of the BCBA, BCBA-D, or other TRICARE authorized ABA provider.

**9.2** The BCBA, BCBA-D, other TRICARE authorized ABA provider (practicing within the scope of his/her state license or state certification), or MCSC shall send the referring P-PCM or specialized ASD provider as defined in [paragraphs 5.7.1.1](#) and [5.7.1.2](#) the initial ABA assessment, the ABA TP, and all ABA TP updates and shall respond to referring provider questions regarding the ABA TP. All ABA providers and referring providers shall maintain clinical records in accordance with medical records requirements set forth under the TRICARE Basic Program.

**9.3** The TRICARE authorized provider administering the baseline and every 180 day psychometric testing shall send the reports of psychometric findings to the referring P-PCM or specialized (non-psychologist) ASD provider (as defined in [paragraphs 5.7.1.1](#) and [5.7.1.2](#)) and the MCSC.

**9.4** The MCSC shall require the BCBA, BCBA-D, or other TRICARE authorized ABA provider (practicing within the scope of his/her state license or state certification) to send the initial ABA TP and the ABA TP annual updates to the MCSC no later than one month prior to current authorization expiration. The MCSC shall transmit the ABA TP to the referring provider. For the TOP, the TRICARE eligible family member/caregivers, the authorized referring provider, the ABA provider shall work together with the TRICARE authorized provider conducting baseline and every 180 day psychometric testing to ensure that the referring provider receives the initial ABA assessment, ABA TP, all ABA TP updates and the reports of all psychometric testing.

**9.5** The referring P-PCM or specialized ASD provider shall review and sign the initial ABA TP, all ABA TP updates and the baseline and every 180 day psychometric testing reports.

**9.6** The referring P-PCM or specialized ASD provider shall review the initial ABA TP, all ABA TP updates and the psychometric testing reports with the TRICARE eligible family member/caregiver and the beneficiary directly receiving ABA during the annual clinic visits. The provider shall write a new referral for repeat psychometric testing to assess progress (every 180 days) and for continued ABA (annually) if the psychometric testing reports support continued appropriate ABA.

## **10.0 QUALITY ASSURANCE**

**10.1** Given that ABA involves provision of care to a vulnerable patient population, the MCSC/TOP/Uniformed Services Family Health Plan (USFHP) contractor shall have a process in place for evaluating and resolving TRICARE eligible family member/caregiver concerns regarding ABA provided by the BCBA, the BCBA-Ds or other TRICARE authorized ABA providers (practicing within the scope of their state license or state certification). This includes ABA reinforcement provided under the supervision of such ABA providers under the Autism Demonstration and ABA Pilot.

**10.2** The process shall include identification of a beneficiary family member/caregiver complaint officer for each regional MCSC/TOP/USFHP contractor. Contact information shall be provided to all TRICARE eligible family member/caregivers of beneficiaries receiving ABA under the TRICARE Basic Program.

**10.3** Allegations of risk to patient safety must be reported to the MCSC Program Integrity (PI) unit and TMA PI must also be advised of alleged risk to patient safety by a provider of ABA. The MCSC PI

unit must take action in accordance with the TOM, [Chapter 13](#), developing for potential patient harm, fraud, and abuse issues.

**10.4** Potential complaints shall be ranked by severity categories. Allegations involving risk to patient safety are to be considered the most severe and shall be addressed immediately and reported to the required agencies. For example, allegations of physical, psychological or sexual abuse shall be addressed through immediate reporting to state Child Protective Services, to the BACB and to state license or certification boards as indicated, in accordance with other governing laws, regulations, policies and mandated reporting requirements. The TOP contractor shall report allegations of abuse to the host nation authorities responsible for child protective services and to the BACB, and to state license or certification boards as appropriate.

**10.5** TRICARE may not cost share services of a BCBA, BCBA-D, or other TRICARE authorized ABA providers (practicing within the scope of their state license or state certification) who has any restriction on their certification imposed by the BACB or any restriction on their state license or certification for those having a state license or certification.

**10.6** Potential categories requiring quality monitoring and oversight are:

- Fraudulent billing practices;
- Lack of progress due to poor quality of ABA;
- Lack of an ASD diagnosis from a provider qualified to provide such per [paragraph 5.7](#);
- Lack of an ABA referral from a TRICARE authorized ASD referring provider as per [paragraph 5.8](#);
- Lack of the required psychometric testing reports for baseline and every 180 day monitoring of ABA progress as per [paragraphs 5.8.3](#) and [5.8.4](#), and/or
- Lack of maintenance of the required medical record documentation.
  - Billing for office supplies to include therapeutic supplies.
  - Billing for ABA using aversive techniques.

**10.7** Risk Management policies and processes shall be established by the MCSCs for the BCBAs, BCBA-Ds and other TRICARE authorized ABA providers practicing within the scope of their state license or state certification.

## **11.0 QUALITY OVERSIGHT MONITORING**

**11.1** Clinical requirements for documentation on the initial ABA TP and ABA TP updates shall be defined by the TRICARE Regional Offices to establish enterprise-wide documentation standards. See [http://www.bacb.com/Downloadfiles/ABA\\_Guidelines\\_for\\_ASD.pdf](http://www.bacb.com/Downloadfiles/ABA_Guidelines_for_ASD.pdf), Guidelines: Health Plan

Coverage of ABA Treatment for ASD (2012). Documentation requirements shall address the requirements for:

- Session progress notes that identify the specific ABA intervention used for each behavioral target;
- At minimum, progress notes should contain the following documentation elements in compliance with [Chapter 1, Section 5.1](#), "Requirements For Documentation Of Treatment In Medical Records":
  - Date and time of session
  - Length of session
  - Current status of beneficiary
  - Content of the session
  - Therapeutic interventions delivered
  - Beneficiary response to interventions
  - Beneficiary progress toward meeting each objective and goal
- TP update assessment notes addressing progress toward short-term and long-term treatment goals for the identified targets in each domain;
- Documentation on the initial ABA TP and the ABA TP updates of the level of support required for the beneficiary to demonstrate progress toward short and long-term goals (Note: The level of support required to demonstrate progress is important because it is directly associated with severity of the ASD and is an important factor in determining the number of hours ABA per week to authorize);
- Documentation of baseline and thereafter every 180 days for ABA progress as measured by the age appropriate required standardized psychometric testing (VBS-II); and
- Documentation of TRICARE eligible family member/caregiver engagement and implementation of the ABA TP at home.

**11.2** TRICARE Quality Monitoring Contractor (TQMC) shall perform random record review for coding compliance and quality monitoring of the ABA TP every 180 days. TQMC findings of improper coding compliance shall be reported to the MCSC PI unit for potential development in accordance with TOM, [Chapter 13](#).

## **12.0 EFFECTIVE DATE**

Requirements of this revised policy are effective July 25, 2013. Claims for ABA prior to July 25, 2013 will continue to be paid in accordance with the guidance provided in TPM, Change 73, published on August 10, 2012.

- END -



## Chronic Fatigue Syndrome (CFS)

Issue Date: September 23, 1991

Authority: [32 CFR 199.4\(g\)\(15\)](#)

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### 1.0 DESCRIPTION

Chronic fatigue is defined as self-reported persistent or relapsing fatigue of **six** or more consecutive months. Chronic Fatigue Syndrome (CFS) is an illness characterized by prolonged, debilitating fatigue and multiple non-specific symptoms such as headaches, recurrent sore throats, muscle and joint pains and cognitive complaints. CFS is treated as a subset of prolonged fatigue. Prolonged fatigue is defined as self-reported, persistent fatigue of **one** month or longer. The presence of prolonged or chronic fatigue requires clinical evaluation to identify underlying or contributing conditions that require treatment. There is no known cure for CFS. Symptoms usually disappear within three to five years. CFS is also known in other countries as myalgic encephalomyelitis, postviral fatigue syndrome, and chronic fatigue and immune dysfunction syndrome.

**Note:** Some methodologic problems with CFS research include inadequate sampling procedures, lack of controls, small sample size, short duration of treatment and follow-up considering the chronicity of the illness, poorly defined operational criteria, and the absence of accurate and reliable diagnostic and outcome indicators. The absence of objective response markers in the treatment of CFS has forced researchers to rely on highly subjective measures such as a reduction in the perception of fatigue. A great deal of controversy and speculation of the syndrome's heterogeneity, researchers argue against it being a discrete disease caused by one agent. Some researchers believe CFS represents a common set of symptoms triggered by different combinations of various infectious and noninfectious factors. Furthermore, little is known about the long-term treatment efficacy of this disorder, and there is not medical consensus regarding the treatment of CFS.

### 2.0 POLICY

**2.1** Medically necessary benefits for otherwise covered services and supplies required to rule out other causes of protracted fatigue are covered.

**2.2** Benefits for CFS are limited to relieving individual symptoms, such as prescribing analgesics for headache or muscle pains. In those cases where there are irregular lab findings, treatment is covered for the identified causes.

### 3.0 EXCLUSIONS

**3.1** **CFS.**

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Chronic Fatigue Syndrome (CFS)

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**Note:** Separately identifying and coding all presenting manifestations of the syndrome is not necessary since they are included in the code assignment.

**3.2** The use of tests to diagnose CFS since such tests are unproven and do not aid in diagnosis or management of CFS.

**Note:** No test can be recommended for the specific purpose of diagnosing CFS. Tests should be directed toward confirming or excluding other possible clinical conditions. Examples of specific tests that do not confirm or exclude the diagnosis of CFS include serologic tests for Epstein-Barr virus, enteroviruses, human herpesvirus 6, and *Candida albicans*. Tests of immunologic function, including cell population and function studies; and imaging studies, including magnetic resonances imaging scans and radionuclide scans (such as single-photon emission computed tomography and positron emission tomography).

- END -

## Chapter 8

## Section 2.6

# Breast Pumps

Issue Date: August 8, 2005

Authority: [32 CFR 199.4\(d\)\(1\)](#)

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### 1.0 HCPCS PROCEDURE CODES

Level II Codes E0604, A4281 - A4286.

### 2.0 DESCRIPTION

Electric breast pumps facilitate the transfer of protective maternal immunoglobulins through breast milk for premature infants. Premature infants suffer varying degrees of immunological immaturity because they do not experience full transplacental transfer of maternal immunoglobulins which mainly occurs during the last several weeks of gestation. In lieu of active maternal transfer, immunoglobulins can be transferred to the premature infant via breast milk. Since premature infants often cannot breastfeed successfully, an electric breast pump ensures that these infants receive an adequate supply of breast milk to address their immunological challenges.

### 3.0 POLICY

**3.1** Heavy-duty hospital grade (E0604) electric breast pumps are covered (including services and supplies related to the use of the pump) for the mother of a premature infant. A premature infant is defined as a newborn with International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes 765.0 (extreme immaturity), 765.1 (other preterm infants), or 765.21 through 765.28 (up to 36 weeks gestation) for services provided **on or before September 30, 2014** or International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes P07.00 - P07.03 (extremely low birth weight (unspecified weight-999 grams)), P07.10 - P07.18 (other low birth weight (unspecified weight, 1000-2499 grams)), P07.20 - P07.26 (extreme immaturity (unspecified weeks-27 completed weeks)), P07.30 - P07.39 (other preterm (unspecified, 28-36 completed weeks)) for services provided on or after **October 1, 2014**.

**3.1.1** An electric breast pump is covered while the premature infant remains hospitalized during the immediate postpartum period.

**3.1.2** Electric breast pumps may be covered after the premature infant is discharged from the hospital. However, a physician must document the medical reason for continued use of an electric breast pump after the infant has been discharged. This documentation is also required for those premature infants (as defined in [paragraph 3.1](#)) who are delivered in non-hospital settings.

**3.2** Equipment cost-sharing is subject to the provisions of the Durable Medical Equipment (DME)/Basic Program.

**4.0 EXCLUSIONS**

**4.1** Electric breast pumps are specifically excluded for reasons of personal convenience (e.g., to facilitate a mother's return to work), even if prescribed by a physician. Coverage is limited to the conditions described in [paragraph 3.0](#).

**4.2** Manual breast pumps (E0602) are excluded.

**4.3** Basic electric breast pumps (E0603) are excluded.

- END -

## Chapter 9

## Section 2.2

# Eligibility - Qualifying Condition: Mental Retardation

Issue Date: July 3, 1997

Authority: [32 CFR 199.5\(b\)\(2\)\(i\)](#), 10 USC 1079(d)(3)

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### 1.0 POLICY

**1.1** A diagnosis of moderate or severe mental retardation in accordance with the criteria in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, is a Extended Care Health Option (ECHO) qualifying condition.

**1.2** For a beneficiary less than three years of age, the following conditions (International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes cited for services provided **on or before September 30, 2014**, or International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes cited for services provided on or after **October 1, 2014**) may be presumed to precede a diagnosis of moderate or severe mental retardation:

- Rett's syndrome: ICD-9-CM 330.8 / ICD-10-CM F84.2
- Down syndrome: ICD-9-CM 758.0 / ICD-10-CM Q90.0-Q90.9
- Fragile X syndrome: ICD-9-CM 759.83 / ICD-10-CM Q99.2
- Fetal alcohol syndrome: ICD-9-CM 760.71 / ICD-10-CM Q86.0

**1.3** For a beneficiary less than three years of age, a developmental delay qualifies as moderate or severe mental retardation when standardized diagnostic psychometric tests demonstrate developmental delay equivalent to two standard deviations below the mean in adaptive, cognitive, or language function

### 2.0 EXCLUSIONS

**2.1** Unless the requirements of [paragraph 1.3](#) are met, the spectrum of Attention-Deficit and Disruptive Behavior Disorders are not considered qualifying conditions for the ECHO.

**2.2** Learning disorders, individually and collectively, are not qualifying conditions for eligibility under the ECHO.

### 3.0 EFFECTIVE DATE

September 1, 2005.

- END -



## Eligibility - Qualifying Condition: Serious Physical Disability

Issue Date: July 3, 1997

Authority: [32 CFR 199.5\(b\)\(2\)\(ii\)](#), 10 USC 1079(d)(3)

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### 1.0 POLICY

**1.1** Any physiological disorder or condition or anatomical loss affecting one or more body systems which has lasted, or with reasonable certainty is expected to last, for a minimum period of 12 contiguous months, and which precludes the person with the disorder, condition or anatomical loss from unaided performance of at least one of the following major life activities is an Extended Health Care Option (ECHO) qualifying condition: breathing, cognition, hearing, seeing, and age appropriate ability essential to bathing, dressing, eating, grooming, speaking, stair use, toilet use, transferring, and walking.

**1.2** For a beneficiary less than three years of age, a developmental delay qualifies as a serious physical disability when the score on the standardized diagnostic psychometric tests of motor function is 2 standard deviations below the mean.

**1.3** Serious physical disabilities include, but are not limited to the following conditions (International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes cited for services provided **on or before September 30, 2014** or International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes cited for services provided on or after **October 1, 2014**) for the purpose of establishing an ECHO qualifying condition:

**1.3.1** Infantile Cerebral Palsy: ICD-9-CM 343.0 - 343.9 / ICD-10-CM G80.0 - G80.9.

**1.3.2** Spina Bifida: ICD-9-CM 741.0 - 741.93 / ICD-10-CM Q05.0 - Q05.9.

**1.3.3** Vision: ICD-9-CM 369.01 - 369.08 inclusive; 369.11 - 369.14 inclusive; 369.21; 369.22; 369.4 / ICD-10-CM H54.0 - H54.12 inclusive; H54.8.

**1.3.4** Hearing-Testable Patients: as determined by audiologic function tests:

- A pure tone hearing threshold level of 45 decibels or greater in one ear; or by
- A pure tone hearing threshold level of 30 decibels or greater in both ears; or by
- Speech discrimination of 60% or poorer with either ear.

**1.3.5** Hearing-Non-Testable Patients: Where pure tone audiometry or speech discrimination testing is not available or reliable, the attending physician must submit documentation which demonstrates the patient is unable to engage in basic productive activities of daily living expected of unimpaired persons of the same age group.

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- 1.3.6** Breathing: Total reliance upon a respirator.
- 1.3.7** Acquired or congenital total loss, or loss of use, of an arm or leg.
- 1.3.8** Autism: Associated with deficits in one or more body systems.

**2.0 EFFECTIVE DATE**

September 1, 2005.

- END -