Understanding ABA Billing and Revenue Cycle Management

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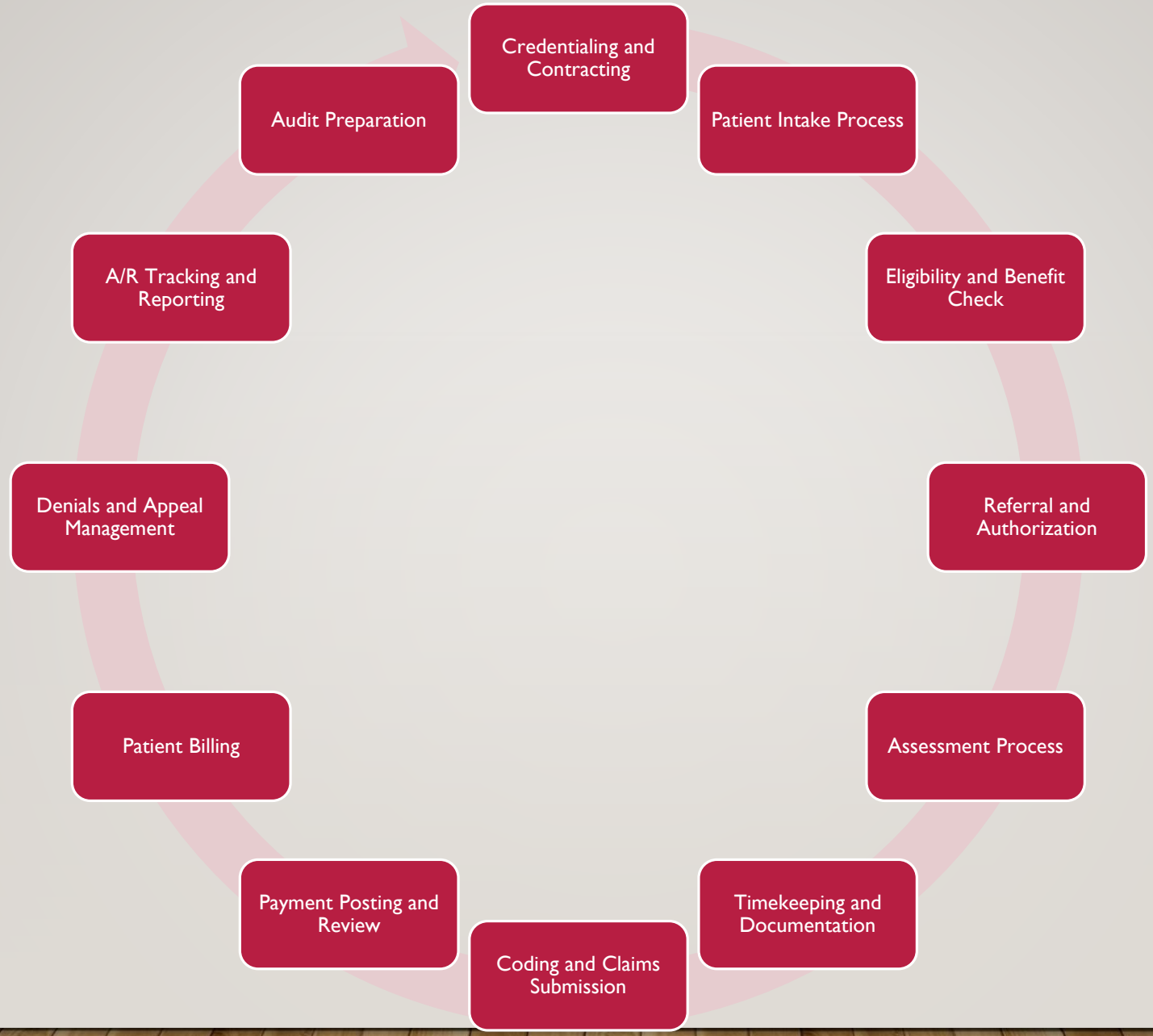
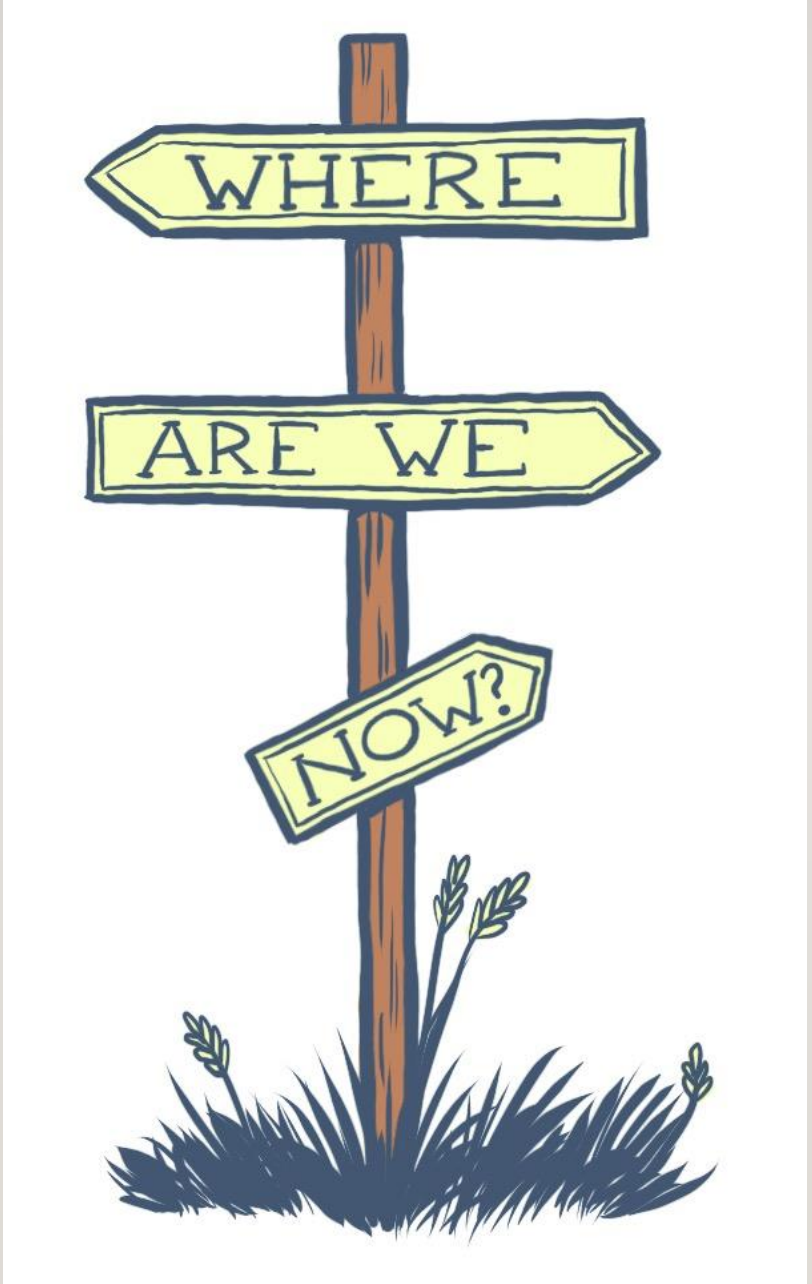
WHAT IS REVENUE CYCLE MANAGEMENT?

- Revenue Cycle Management (RCM) is the process to set yourself up for success in being reimbursed for services performed through various funding sources. It is the full cycle from credentialing and contracting with funding sources, to patient intake, to reimbursement of claims and recording in accounting software.
- For healthcare insurance funders, it includes the proper steps to complete prior to generating claims to ensure the highest level of compliance for reimbursement. The revenue cycle consists of payer policies and guidelines, claims submission, denials and appeals and the tracking of each aspect of the cycle.
- The financial aspect of the revenue cycle can determine your risks and strengths in remaining solvent in your practice as well as your success in passing audits. Maintaining ethical billing standards and compliance are key to contributing to the best practices of client/patient care, combating fraud, waste and abuse according to CMS standards.

Establish efficient processes and critical checks and balances for each key area of the Revenue Cycle.




WHERE
ARE WE
NOW?

CATEGORY I CPT CODES ADAPTIVE BEHAVIOR SERVICES INTENT

- INTENT:
  - We are past the "intent" phase but…
  - We cannot move on without being fully educated on all resources for intent
    - CPT 2019 Code book, available from the American Medical Association (AMA) Store
    - Article in the November 2018 issue of the CPT Assistant newsletter published by the AMA
      - To purchase just the November 2018 issue, call 1-800-621-8335, select option 2 in the recorded menu, and ask for item BI506118. The cost is $19.95; $14.95 for AMA members).
    - APBA Recorded Webinars
    - APBA Member Resources
      - CPT Codes Conversion Table
      - New CPT Codes – Suggestions for Providers
      - CPT MUE's
      - New CPT Codes – Supplemental Guidance

CATEGORY I CPT CODES ADAPTIVE BEHAVIOR SERVICES IMPLEMENTATION

- IMPLEMENTATION:
  - We are in the IMPLEMENTATION PHASE… what does that mean?
    - Continued Education
      - Stay connected to relevant resources
    - Watching Payer Behavior
      - Have conversations with health plans during Authorization
      - Watch how authorizations match to your medically necessary requests
      - Request and review your new Fee Schedules
    - Advocacy
      - We've only just begun… don't give up!

STRIKING A BALANCE BETWEEN INTENT AND IMPLEMENTATION

EXAMPLE OF BALANCE #1: CONCURRENT BILLING

INTENT

- Per the Steering Committee Guidance, it is the Intent of Codes 97155 (Protocol Modification with Simultaneous Direction) and 97153 (Treatment by Protocol) to be billed Concurrently.

IMPLEMENTATION

- Providers do not need to seek to have this in writing to move forward, the language of the code and supplemental guidance reflect intent and purpose.
- Providers do, however, need to watch for documented payer policies that "disallow" this and continue to educate health plans of the intent.

CONCURRENT BILLING…CONTINUED

- The descriptor for code 97155 adds that the service may include *simultaneous* direction of a technician by the QHP, and the CPT Assistant article reads: "Adaptive behavior treatment by protocol (97153) is administered by a technician under the direction of a physician/other QHP, who may provide direction during the actual treatment, which represents face-to-face treatment delivered to a patient.
- The QHP designs the treatment protocols, assists the technician in adhering to the protocols, and analyzes the technician-recorded data to determine whether the protocol is producing adequate progress (97155)" and "Code 97155 may be reported in two scenarios: when the QHP is delivering the treatment with the client (according to the code descriptor) one-to-one or when the QHP is directing the technician in delivering treatment (code 97153) and both the technician and the client are present."
- Both the CPT code book and the CPT Assistant article list codes that cannot be billed concurrently with each of the codes in the 2019 code set. For 97155 that list does not include 97153.

EXAMPLE OF BALANCE #2: TREATMENT BY PROTOCOL

INTENT

- Per the Steering Committee Guidance and CPT Manual, Treatment by Protocol can be substituted by a QHP.
- With this substitution, health plans should be willing to provide a means for a QHP reimbursement rate to be equivalent to that provider level of service.

IMPLEMENTATION

- Some health plans do have a means to identify the level of provider rendering treatment by protocol and reimburse at a matching rate (eg TRICARE billing by provider or funders with modifiers and matching rates on fee schedules).
- Some health plans have documented that this service will be reimbursed at the technician rate without modifier.

EXAMPLE OF BALANCE #3: SUPERVISED FIELDWORK VS DIRECTION OF TECHNICIAN

(PARAPHRASED FROM THE SUPPLEMENTAL GUIDANCE)

DIRECTION

"Direction" refers to the QHP directly monitoring the delivery of treatment to a patient by a behavior technician. The focus is on ensuring that treatment protocols are implemented correctly in order to maximize benefit to that patient.

Direction of a technician includes, but is not limited to, the QHP frequently observing the technician implementing the patient's protocols with the patient, providing instructions and confirming or corrective feedback as needed, and/or demonstrating correct implementation of a new or modified treatment protocol with the patient while the technician observes, followed by the technician implementing the protocol with the patient while the QHP observes and provides feedback.

Time reported and billed must be face-to-face time with the patient.

SUPERVISION

"Supervision" of a technician or other employee by a QHP generally refers to processes through which the QHP ensures that the supervisee

(a) practices in a competent, professional, and ethical manner in accordance with the standards of the profession; (b) engages with and follows the employer's policies and procedures; (c) continues to develop their knowledge and skills; and (d) receives the personal support needed to cope with the stressors and demands of their position.

"Supervision" may also involve activities to enable compliance for obtaining or maintaining a professional credential, or to fulfill ethical responsibilities.

Supervision activities that do not involve delivery of services directly to patients are generally not reportable or billable to health plans using CPT codes, though some payers may allow them to be billed using HCPCS or other codes.

EXAMPLE OF BALANCE #4: MUE LIMITS

INTENT

- CMS published MUE (medically unlikely edit) limits are applied to Adaptive Behavior Service Category I codes.
- CMS agreed to modify 97151 from 2 hours "per day" to 8 hours per day and will publish this change 4/1/19.

IMPLEMENTATION

- Health plans that apply MUE limits may apply the 97151 early limit until the published change.
- TRICARE has identified their own MUE limits per code.
- MUE limits are not guidelines for requesting what is medically necessary for treatment.

EXAMPLE OF BALANCE #5: RATES

INTENT

- With new Codes, new Fee Schedules should follow.
- With new Fee Schedules, discussion of appropriate rates should be an option.
- With new Codes and Fee Schedules, discussion of Code intent and full program needs should be allowed.

IMPLEMENTATION

- Most plans have self cross-walked current Fee Schedules from old codes to new codes based on their interpretation.
- Continued Education needs to occur using the materials and resources that describe intent of the codes and the needs required for an ABA program.
- Providers should bill their Usual and Customary Rate and not contracted rate.

DEEPER DIVE INTO: BEHAVIOR IDENTIFICATION ASSESSMENTS

Per the Steering Committee Supplemental Guidance sent to Providers or found in the Members Only section of www.apbahome.net

- Q: Is 97151 intended to be used for day-to-day assessment and treatment planning?
- A: No. This code is intended for reporting initial assessment and treatment plan development and reassessment and progress reporting by the QHP (timeframes for reassessments are determined by payer policy or medical necessity). 97151 includes face-to-face time with the patient and/or caregivers to conduct assessments as well as non-face-to-face time for reviewing records, scoring and interpreting assessments, and writing the treatment plan or progress report. The QHP must have conducted both the face-to-face and non-face-to-face activities to report this service. Day-to-day assessment and treatment planning by the QHP are bundled into the treatment codes 97153-97158 and 0373T; therefore, 97151 cannot be used to report those indirect services because they do not meet all requirements of the code descriptor.

97151 – BEHAVIOR IDENTIFICATION ASSESSMENT …CONTINUED

- CPT code 97151 is for development of an initial or revised treatment plan as well as assessment to identify initial or revised treatment targets by the QHP (LBA or BCBA). There is no code for ongoing assessment and revision of treatment targets and protocols by the QHP in the Category I codes for Adaptive Behavior Services.
- Those "indirect services" are bundled with the new treatment codes, meaning that providers need to negotiate rates for those codes that take into account not only the direct treatment of the client by the technician or QHP, but also the work the QHP does before and after treatment sessions.
- Providers also should seek to request a stand alone code for Treatment Planning whenever possible.

97152 – BEHAVIOR IDENTIFICATION SUPPORTING ASSESSMENTS

- Q: Does the descriptor for 97152 indicate that technicians can perform assessments independently?
- A: No. This code is for reporting supplemental assessments conducted by the technician that the QHP determines are needed to develop the treatment plan or progress report (see code 97151). Additionally, as indicated in the clinical example, the QHP reviews the assessment procedures with the technician and has the technician practice recording data. That may occur on the day of an assessment session with a patient or several days leading up to the session(s). That work by the QHP is bundled into the value of code 97152 and is not reported separately.

PROTOCOL MODIFICATION

(PARAPHRASED FROM THE SUPPLEMENTAL GUIDANCE)

- Adaptive behavior service protocol modification involves changes made by the QHP to the procedures for implementing an adaptive behavior service.
- Protocol modification includes but is not limited to
  - (a) adjustments to specific components of a protocol (e.g., treatment targets, treatment goals, observation and measurement, reinforcers, reinforcer delivery, prompts, instructions, materials, discriminative stimuli, contextual variables); (b) observations to determine if the protocol components are functioning effectively for the patient or require adjustments; (c) active direction of a technician while the technician delivers a service to a patient to ensure that the procedures are being implemented correctly, to correct errors in implementation, or to train the technician to implement a modified protocol; and (d) QHP implementation of the protocol with the patient to determine if changes are needed to improve patient progress or to test a modified protocol.

SESSION NOTE DOCUMENTATION

- Follow standard session note documentation requirements for accurate reflection of session in and out times; provider and client information, narrative summaries, etc.
- To safeguard during audit, review and understand the intent of the codes.
- The session note must clearly state what occurred during the session, even if it was determined by the QHP not to modify protocol at this time.
- Protocol modification can occur with or without the technician present.
- Protocol modification services that are delivered during face-to-face sessions with patients or caregivers are billable. Modifying written protocols is an indirect service that is not reported separately, but is bundled with 97155 for payment.

GROUP THERAPY

- 97158 is intended to be reported for QHP-led group sessions only.
- When performing direction of technician the code used is 97155 and it must be 1:1 per client, per technician with other qualifications of the code descriptor which will then qualify for concurrent billing according to the intent of the codes.
- A group includes at least 2 patients but no more than 8.
- 97154 for technician-led group sessions is reported for each patient attending a group session.
- Each member of the group can have different funding sources (eg specific health plans or private pay).

COMPLIANCE IN ACTION

- Seven components that provide a solid basis upon which a practice can create a voluntary compliance program:

1. Conducting internal monitoring and auditing;
2. Implementing compliance and practice standards;
3. Designating a compliance officer or contact;
4. Conducting appropriate training and education;
5. Responding appropriately to detected offenses and developing corrective action;
6. Developing open lines of communication; and
7. Enforcing disciplinary standards through well-publicized guidelines.

https://oig.hhs.gov/authorities/docs/physician.pdf


What
Do I Do
Now

ACTION TASK LIST

1) Stay educated using reliable, relevant resources!
2) Seek to have discussions with the Medical Directors at the health plans that you work with about topics that matter (rates, misunderstanding of intent of codes, stand alone codes for indirect services)
3) Establish a Compliance Committee and processes for self audits
4) Develop Session Documentation standards that align with the intent of the codes
5) Document Payor Policy revisions for future audits
6) Advocacy efforts!

ETHICAL BILLING PRACTICES

- During this time, don't lose sight of Ethical Billing practices to keep your organization out of harm's way of unintended fraudulent billing or what may be perceived as abuse in an audit.
  - Be sure your internal team or outsourced billing company is using all available resources and is well versed in the intent of the codes and staying connected with published payer policies for each health plan you work with.
  - Recognize that some health plans were using the Category III codes in non-standard ways. For example, TRICARE independently utilized 0360T/0361T for Supervised Fieldwork which was a non-standard use of a code that did not correlate with this service. Other health plans had granted authorization and/or given guidance to use the Category III codes for non face-to-face activities, despite the language of the code referencing Category III codes were also for face-to-face activities.
  - Ground yourself in the difference between Case Supervision and supervision related to an RBT certificant. Many activities performed during Protocol Modification while simultaneously directing a technician may qualify for the certificant supervision requirements, but some may be considered practice and overhead expense.
  - Know that there could be a period of time where there is not a stand-alone code for indirect services and plan accordingly.

ADVOCACY IS ESSENTIAL

- Use all available resources to discuss the intent of the codes with Payers
  - Payer provider reps and claims specialists are learning the codes too.
  - If the Payer Policy is not documented and published, don't take the guidance in a phone call that is misaligned with the intent without seeking to speak to a decision maker with the health plan and ask for information in writing.
  - The Supplemental Guidance was designed to SHARE with health plans during discussion.
- Advocate for your Business!
- Participate in your state ABA Chapter
  - Become a leader in advocating for the industry.
  - There are ways to collaborate that don't violate anti-trust laws. Be well versed in what is considered a violation and steer clear of those activities; but work together collectively in your mission to educate and train the health plans to better understand the intent and implementation needs.

ADDITIONAL RESOURCES

- Association of Professional Behavior Analysts (APBA) Membership
  - Various Resources for Health Insurance Coverage of ABA Services
- APBA 2019 Convention with Workshops related to the Code changes
- Behavior Analysis Advocacy Network (BAAN)
  - Upcoming Webinar on Session Note Documentation
- ABA Therapy Billing and Insurance Services
  - Various Blogs and Recorded Webinars