CPT CODING FOR ABA SERVICES

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OVERVIEW

• WHAT ARE CPT CODES AND HOW ARE THEY DEVELOPED?
• ONCE A CPT CODE EXISTS, HOW IS IT VALUED?
• BACKGROUND ON CODING FOR ABA SERVICES
  • PAST, PRESENT, FUTURE
• WHAT’S ON THE HORIZON?
BACKGROUND / DISCLOSURES

• 8 years of coding and reimbursement experience with national medical specialty societies. Includes expertise in navigating the Medicare and Medicaid reimbursement cycles and other healthcare regulatory issues.

• MHCS conducts consulting services for the following organizations:
  • Association for Behavior Analysis International
  • Association of Professional Behavior Analysts
  • Autism Speaks
  • Behavior Analyst Certification Board
  • Bierman ABA Autism Centers
  • American Academy of Otolaryngology – Head and Neck Surgery

• Director of Operations for Residential Options, Inc.
WHAT ARE CPT CODES?


• The purpose of CPT is to provide a uniform language that accurately describes medical, surgical, and diagnostic services.

• This provides a consistent way to communicate nationwide among physicians and other health care providers, patients and third parties.
CPT & E-REPORTING REQUIREMENTS

• Under HIPAA (the Health Insurance Portability and Accountability Act) Department of Health and Human Services was required to name national standards for electronic transaction of health care information. This includes transactions and code sets, national provider identifier, national employer identifier, security and privacy. The rule names CPT (including codes and modifiers) and HCPCS as the required procedure code sets for all health care plans and providers who transmit information electronically.
HOW IS THE CPT CODE SET MAINTAINED??

• The CPT Editorial Panel is responsible for maintaining the CPT code set. There are 17 members on the Panel.

• Of these, 11 are physicians nominated by national medical specialty societies.

• One is reserved for expertise in performance measurement.

• One physician is nominated from each of the following: the Blue Cross and Blue Shield Association, America’s Health Insurance Plans, the American Hospital Association and CMS.

• The remaining 2 seats on the CPT Editorial Panel are reserved for members of the CPT Health Care Professionals Advisory Committee. The HCPAC contains specialties for non-physician groups such as speech, OT, psychology, etc.
WHO CAN REQUEST A NEW CODE?

• ESSENTIALLY ANYONE: Medical specialty societies, individual physicians, hospitals, third-party payers and other interested parties may submit for consideration by the panel.

• The AMA’s CPT staff reviews all requests to ensure they have not already addressed the question. If the application represents a new issue, the application is referred for evaluation and commentary.

• An open comment period then follows which allows CPT Advisors and the “interested parties” from the public to submit comments and questions.

• Applicants are notified in advance if their CCA has not received any support and have the opportunity to withdraw.
CPT CYCLE:

• The Panel meets 3 times per year to review applications (winter, spring and fall).

• Applications are due approximately 2-3 months in advance of the CPT Editorial Panel meetings.

• This allows time for comment and review by the assigned Panel reviewers. Submitters receive comments in advance and have an opportunity to amend or withdraw based on those comments.

• Submitters may also provide what is known as an “on-site” option if amendments are required during the meeting.
• Addition of a new code or revision of existing codes, in which case the change would appear in a forthcoming volume of CPT
• Referral to a workgroup for further study
• Postponement to a future meeting (to allow submittal of additional information in a new application)
• Rejection of the item
TYPES OF CPT CODES

• **CATEGORY I:** Category I CPT codes are numeric, and are five digits long. They are divided into six sections: Evaluation and Management, Anesthesia, Surgery, Radiology, Pathology and Laboratory, and Medicine. These are permanent codes accepted by CMS and other third party payers.

• **CATEGORY III:** CPT Category III codes are a set of temporary codes that allow data collection for emerging technology, services, and procedures. These codes are intended to be used for data collection to substantiate widespread usage.
CODE SPECIFIC REQUIREMENTS:

CATEGORY I CODES

• All devices and drugs necessary for the procedure or service are FDA approved.

• The procedure or service is performed by many physicians or other qualified health care professionals across the U.S.

• The procedure or service is performed with frequency consistent with the intended clinical use (i.e., a service for a common condition should have high volume).

• The procedure or service is consistent with current medical practice.

• The clinical efficacy of the procedure or service is documented in literature that meets the requirements set forth in the CPT code-change application.
<table>
<thead>
<tr>
<th>Category I Literature Requirements</th>
<th>Utilization</th>
<th>Typical</th>
<th>Typical</th>
<th>Limited, Specialized or Humanitarian</th>
<th>Limited, Specialized or Humanitarian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technology</td>
<td>New</td>
<td>Existing or Non-Contributory</td>
<td>New</td>
<td>Existing or Non-Contributory</td>
<td></td>
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<tr>
<td># of Peer-Reviewed Publications:</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>3-5</td>
<td></td>
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<tr>
<td>Minimum # with U.S. Patient Populations:</td>
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<td>3</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Minimum # with Different Patient Populations:</td>
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<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Minimum Level of Evidence for at least One Article</td>
<td>IIa</td>
<td>IIa/IIIb</td>
<td>IIb</td>
<td>IV</td>
<td></td>
</tr>
<tr>
<td>Make an “X” in the box for the type of utilization and technology that best fits the procedure/literature being requested.</td>
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</tbody>
</table>
CODE SPECIFIC REQUIREMENTS:

CATEGORY III CODES

• The procedure or service is currently or recently performed in humans AND at least one of the following additional criteria has been met:
  • The application is supported by at least 1 Advisor representing practitioners who would use this procedure or service; OR
  • The actual or potential clinical efficacy of the specific procedure or service is supported by peer reviewed literature which is available in English; OR
  • There is (a) at least 1 Institutional Review Board approved protocol of a study of the procedure or service being performed, (b) a description of a current and ongoing United States trial outlining the efficacy of the procedure or service or (c) other evidence of evolving clinical utilization
Coding Change Application

Category I CPT Code(s)
Category III CPT Code(s) – Emerging Technology
American Medical Association, Current Procedural Terminology
(CPT®)

Application Submission Requirements

All CPT Code Change applications are reviewed and evaluated by CPT staff, the CPT/HCPAC Advisory Committee, and the CPT Editorial Panel. Strict conformance with the following is required for review of a code change application:

- Submission of a complete application, including all necessary supporting documents;
- Adherence to all posted deadlines;
- Cooperation with requests from CPT staff and/or Editorial Board members for clarification and
QUESTIONS FOR CONSIDERATION BEFORE SUBMITTING A CCA:

• Is the Suggestion a Fragmentation of an Existing Procedure/Service?

• Can the Suggested Procedure/Service Be Reported by Using 2 or More Existing Codes?

• Does the Suggested Procedure/Service Represent a Distinct Service?

• Is the Suggested Procedure/Service Merely a Means to Report Extraordinary Circumstances Related to Performance of Procedure/Service Already Included in CPT?
WHAT DO I NEED TO SUBMIT A CCA?

• A complete description of the procedure/service (i.e., describe in detail the skill and time involved.).

• A clinical vignette, which describes the typical patient and work provided by the physician/practitioner.

• The diagnosis of patients for whom this procedure/service would be performed.

• A copy(s) of peer reviewed articles published in U.S. journals indicating the safety and effectiveness of the procedure, as well as the frequency with which the procedure is performed and/or estimation of its projected performance.

• A copy(s) of additional published literature which you feel further explains your request (e.g., practice parameters/guidelines or policy statements on a particular procedure/service).

• Evidence of FDA approval of the drug or device used in the procedure/service, if required.
ONCE I HAVE A CODE, HOW IS IT VALUED?

• TWO OPTIONS:
  • Valuation through the AMA Relative Update Committee (RUC) process
  • Remain “carrier priced” and allow individual payers to determine reimbursement rates
WHAT IS THE AMA RUC?

• The RUC is a unique multispecialty committee dedicated to describing the resources required to provide physician services which the Centers for Medicare & Medicaid Services (CMS) considers in developing Relative Value Units (RVUs).

• They do this through standardized surveys sent out by medical specialty societies to members who are familiar with the services being valued.

• Although the RUC provides recommendations, CMS makes all final decisions about what Medicare payments will be. These are released twice a year via the proposed Medicare Physician Fee Schedule (MPFS) (released in July) and the final MPFS (released in November).

• Providers have a chance to comment on the proposed values through the annual rulemaking process.
ENOUGH HISTORY...
ABA CODING: WHERE WE STARTED

• Initial CCA submitted in May 2013
  • Inconsistent coding and reimbursement by payers for ABA services
  • 29 states with ABA coverage mandates
  • The outcome at the May meeting resulted in a workgroup being formed by the CPT Editorial Panel to evaluate the needs of an ABA code set.

• October 2013 CPT Editorial Panel Meeting
  • Category III codes were approved! These codes took effect in July 2014
  • Feedback was obtained almost immediately by many of the ABA societies / organizations that there were concerns with the code set
  • ABAI conducted a survey of members to garner feedback in 2015
  • A Workgroup was formed by ABA organizations (ABAI, APBA, Autism Speaks, and the BACB) and external stakeholders to revise the code set
Steering Committee Efforts included:

• Development and distribution of a **coding crosswalk table** showing how the new Category III codes were intended to be used,

• A survey was sent to over 31,068 ABA service agency administrators and practitioners to evaluate areas for improvement within the current code set. Additionally, 12 national specialty societies were invited to join these efforts,
2016 SURVEY ON UTILIZATION OF CATEGORY III ADAPTIVE BEHAVIOR CODES

• **Survey Method:** We conducted a survey to help us better understand how providers are using these codes using Survey Monkey®. A web link was sent via email to all U.S. constituents of ABAI, APBA, and the BACB. The survey was open for participation for a three-week period and any duplicate responses were removed.
OVERVIEW OF 2016 SURVEY ON UTILIZATION OF CATEGORY III ADAPTIVE BEHAVIOR CODES

• Organizations invited: Twelve organizations that may have constituents who use these codes were invited to participate, which included:
  • Association for Behavior Analysis International (ABAI),
  • Association of Professional Behavior Analysts (APBA),
  • Behavior Analyst Certification Board (BACB),
  • American Speech-Language-Hearing Association (ASHA),
  • American Academy of Neurology (AAN),
  • American Psychiatric Association (APA),
  • American Psychological Association (APA),
  • American Academy of Pediatrics (AAP),
  • American Occupational Therapy Association (AOTA),
  • National Association of Social Workers (NASW),
  • American Counseling Association (ACA), and
  • American Academy of Child and Adolescent Psychiatry (AACAP).

• Organizations participated: The organizations that participated in the survey were primarily behavior-analytic, including BACB, APBA, and ABAI.
OVERVIEW OF 2016 SURVEY ON UTILIZATION OF CATEGORY III ADAPTIVE BEHAVIOR CODES

• **Responses:** The survey was sent to 31,068 constituents of the three organizations above. In total, 861 respondents completed a portion of the survey (2.7%). Of those, 261 respondents completed the survey from beginning to end, for a 0.8% response rate.
WHAT DID YOU HAVE TO SAY?

• Respondents were asked to provide feedback on any areas they perceive that the code set is lacking. The most common services for which respondents indicated they did not have a method of reporting work using the Category III code set and so are utilizing HCPCS codes or CPT codes outside the current code set were:

  • Supervision of a technician by a QHCP – 55 respondents
  • Treatment planning by QHCP – 44 respondents
  • Services with QHCP and technician present – 19 respondents
  • General case management – 9 respondents
PAYER TRENDS/CAPS ON SERVICES:
We inquired about how many respondents worked with at least one payer who capped the amount of time providers can spend on specific ABA services. Thirty-six percent of respondents indicated that their payers cap at least one service.

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>0359T: Assessment</td>
<td>92.5%</td>
<td>86</td>
</tr>
<tr>
<td>0360T: Observational follow-up assessment</td>
<td>60.2%</td>
<td>56</td>
</tr>
<tr>
<td>0370T: Family treatment</td>
<td>55.9%</td>
<td>52</td>
</tr>
<tr>
<td>0364T: Direct treatment by technician</td>
<td>53.8%</td>
<td>50</td>
</tr>
<tr>
<td>0368T: Direct treatment by QHCP</td>
<td>52.7%</td>
<td>49</td>
</tr>
<tr>
<td>0361T: Observational follow-up assessment add on</td>
<td>51.6%</td>
<td>48</td>
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<tr>
<td>0369T: Direct treatment by QHCP add on</td>
<td>41.9%</td>
<td>39</td>
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<tr>
<td>0365T: Direct treatment by QHCP add on</td>
<td>39.8%</td>
<td>37</td>
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<tr>
<td>0362T: Exposure follow-up assessment</td>
<td>30.1%</td>
<td>28</td>
</tr>
<tr>
<td>0366T: Group treatment by technician</td>
<td>29.0%</td>
<td>27</td>
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<tr>
<td>0363T: Exposure follow-up assessment add on</td>
<td>28.0%</td>
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<tr>
<td>0371T: Group treatment by QHCP</td>
<td>25.8%</td>
<td>24</td>
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<tr>
<td>0372T: Social skills by QHCP</td>
<td>25.8%</td>
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<tr>
<td>0373T: Exposure direct treatment 2 techs and QHCP</td>
<td>25.8%</td>
<td>24</td>
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<tr>
<td>0367T: Group treatment by technician add on</td>
<td>24.7%</td>
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<td>0374T: Exposure direct treatment 2 techs and QHCP add on</td>
<td>22.6%</td>
<td>21</td>
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answered question 93
skipped question 168
ABA CODING: PRESENT

• In November 2016, the Workgroup submitted a revised CCA requesting Category I ABA codes for the February 2017 CPT meeting.

• In early February representatives from ABAI, APBA, and Autism Speaks attended the CPT Editorial Panel meeting in New Orleans to present a code change proposal to the Panel.
<table>
<thead>
<tr>
<th>42</th>
<th>Adaptive Behavior Analysis</th>
</tr>
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<tbody>
<tr>
<td>99X01</td>
<td>0366T</td>
</tr>
<tr>
<td>99X02</td>
<td>0367T</td>
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<tr>
<td>99X03</td>
<td>0368T</td>
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<td>99X04</td>
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<td>0364T</td>
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<td>0365T</td>
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</table>

Accepted addition of codes 97X51-97X58 for adaptive behavior treatment; revision of guidelines in the Adaptive Behavior Services section; and revision of codes 0362T 0373T and; deletion Category III codes, 0359T, 0360T, 0361T, 0363T, 0364T, 0365T, 0366T, 0367T, 0368T, 0369T, 0370T, 0371T 0372T, 0374T.
ABA CODING: FUTURE

• The Panel approved 9 new Category I CPT codes for ABA services and retained / revised two Category III codes.

• Information related to the new Category I, and revised Category III, codes will be available in the 2019 CPT Code book, typically released in August of the preceding year (August 2018 in this case).

• **THESE CODES TAKE EFFECT ON JANUARY 1, 2019.**
ABA CODING: FUTURE – 2017 EFFORTS

• Development of a “Payer Packet”
  • Model coverage policy
  • Updated Coding Crosswalk Chart
  • Reimbursement crosswalk recommendations – using comparisons to other “like” services’ relative value units (RVUs) and practice expense within the MPFS
ABA CODING: FUTURE

**Payer Education**

- Includes continuing to work with payers on utilization of the existing crosswalk table to improve consistency in use of the Cat III code set until 2019
- Development of additional tools for providers to use in negotiations with payers as well as to educate them on the importance and efficacy of ABA
- Obtaining accurate NCCI and MUE edits for new codes

**Provider Education**

- Expand information available to, and knowledge base of, providers related to payer interaction and contracting
- Compliance with Antitrust Laws is KEY!
- Educate on considering all components of a “service” (overhead, practice expenses, staff, therapists, technology, liability insurance, indirect time / case management etc.). KNOW YOUR OWN INFORMATION!
WHAT ELSE SHOULD I DO TO PREPARE?

• **Review your contracts.** What is the notice requirement for changes to fees or other key terms? Self education is key! Know your payer policies, understand the requirements for medical necessity / coverage as well as the terms for modification of your agreements.

• **Talk to you payers.** Are they aware of the coding changes? Send them notifications and engage them. Share your resources from the AMA and ABA Associations etc.

• **Negotiate!** It may not always seem like it, but rates in your contracts are always negotiable – start early dialogue with payers!

• **Ask questions!** Engage a consultant or national organization with information to assist you in the transition (i.e. understanding the new codes, implementing them into your EMR, etc.)
• **Restrictive Coding Edits**
  
  • Last year providers contacted the Steering Committee expressing concern that payers are limiting units of ABA services per day, based on CMS policy.

  • Why is this happening???
ABA CODING: MEDICALLY UNLIKELY EDITS (MUE)

• After codes go through the CPT process, CMS uses a contracted agency called the National Centers for Correct Coding Initiative (NCCI) to establish different types of coding edits. For more visit: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/nationalcorrectcodinginitiated/

• Part of this process includes setting procedure to procedure edits (i.e. what services / codes can be billed together on a given date of service) as well as medically unlikely edits (i.e. the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service).
After looking into the rationale by payers for limiting ABA services such as direct treatment and direction of technician / caregiver by a BCBA/QHCP (0364/65T and 0368/69T), we discovered that the MUE edits for these codes were set at very low daily caps.

In response, the Steering Committee contacted NCCI in the fall of 2016 and requested modification of the MUE edits to increase them to medically necessary, and clinically appropriate levels for all types of patients.
ABA CODING: MEDICALLY UNLIKELY EDITS (MUE)

• After hearing from providers again in early 2017, the Steering Committee conducted a brief survey of providers of varying sizes, demographics, and locations to garner feedback on what the appropriate daily maximum units should be.

• We again reached out to NCCI requesting an increase to the MUE edits for these code combinations. They included: 0365T, 0369T and 0374T.
SUCCESS!!!

- Effective October 1, 2017, MUE edits for the following code pairings were INCREASED!
  - 0364/65T can now be provided for a total of 8 hours per day
  - 0368/69T can now be provided for a total of 6 hours per day
  - 0373/74T can now be provided for a total of 6 hours per day
Well I caught it

Now what?
THE OUTLOOK IS POSITIVE BUT WE STILL HAVE WORK TO DO…

• This is a “new field” from the medical communities’ perspective – we have a responsibility to educate

• Scope of practice / collaboration with schools and other healthcare practitioners – medical necessity across care settings and the lifespan

• HIPAA compliance and correct coding initiatives – commitment to sound reporting and compliance with payer requirements / policy

• Education to clinicians about importance of sound business practices and accurate documentation / reporting – commitment to ethics in ABA and promulgation of the field using the highest standards of care
QUESTIONS???

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