Florida Association for Behavior Analysis

June 10, 2022

Agency for Health Care Administration
Bureau of Medicaid Policy
2727 Mahan Drive, Mail Stop #23
Tallahassee, FL 32308

Re: 59G-4.002, Provider Reimbursement Schedules and Billing Codes

To Whom It May Concern:

The Florida Association for Behavior Analysis expresses its appreciation to the Agency for Health Care Administration for working with FABA and providers of behavior analysis to make the transition to the revised fee schedule and CPT billing codes as smooth as possible and to make certain that effective and ethical behavior analysis services are available to all Florida Citizens.

In the months since the proposed 59G-4.002 was released, FABA has received feedback from many providers who are genuinely concerned with continuing to serve individuals with serious behavioral needs in our state. Of the many issues raised, the two primary concerns were:

1. **The rate table does not provide a modifier for procedure code 97153 when the treatment protocol is implemented by a BCBA-D, BCBA, BCaBA or FL-CBA**. Thus, when ongoing implementation of the treatment plan requires the skills of a more qualified practitioner, they must bill at the RBT rate (a 36% rate cut for BCBAs). Or, the service must be delivered by an RBT. Either situation is untenable.

   FABA supports the tiered model of service delivery. When appropriate, a BCBA-D, BCBA, BCaBA or FL-CBA works toward the goal of fading interventions so that an RBT and/or family member can provide the services. However, we must take care in determining situations when this would NOT be appropriate. FABA requests AHCA to recognize that although RBTs provide a valuable service, their training is limited to 40 hours and it is beyond their scope of competence to effectively, safely and ethically serve individuals with all types of challenging behaviors. Severe aggression, self-injury, food refusal, and pica are several examples of potentially life-threatening behaviors that require advanced skills and decision-making abilities that must be acquired through extensive university coursework and supervised fieldwork. In such situations, direct delivery of intervention by a BCBA-D, BCBA, BCaBA or FL-CBA is a necessity.

   The lack of a 97153 modifier conflicts with recommendations from the AMA that state services provided by a professional behavior analyst rather than an RBT should be reported with an appropriate modifier and reimbursed at a rate that is appropriate for the professional-level provider.

There are additional situations that warrant treatment provision by a BCBA-D, BCBA, BCaBA or FL-CBA rather than a RBT. For example, when limited hours are authorized for a treatment, it can be most effective for one practitioner to provide all of the services. Another situation is when more intensive services are being faded so that an RBT and/or family members can provide the treatment.

There also a variety of workforce issues that impact the availability of RBTs in some areas, especially those that are remote or rural. When a local RBT is not available, it is impractical to expect a distant RBT to incur the hardships of extensive travel time and expenses to provide the treatment. The lack of available RBTs will also present a great hardship to families who will struggle to find service providers.

FABA is very concerned that the fee schedule is not "budget neutral." We have been told that the lack of a 97153 modifier is because AHCA wants to pay for a service and not pay based on the qualifications of the provider. However, the policy language is inconsistent since the use of modifiers for other codes such as 97155 and 97156 have been included.

Without a 97153 modifier, the fee schedule will produce a major rate cut when services are provided by a BCBA-D, BCBA, or BCaBA. If "behavior treatment by protocol" would be reimbursed at a maximum rate of $12.19 for behavior analysts and RBTs, this would be a 36% reduction to BCBA providers. This will cause a hardship in meeting operating expenses, especially given recent inflation figures. Providers may be forced to curtail or cease operations and lay off staff which would reduce services for many clients. Our providers have informed us if modifiers are not added to 97153, many children with serious challenging behavior will lose services from their current providers.

Code 97153 XP is not clearly defined, does not appear to be reimbursable, and it is unclear how or when the code will be used. There are concerns that additional administrative costs will occur for some providers due to increased note requirements and if the code may be used to trigger payback and other negative consequences for providers even though adequate supervision is occurring, but under circumstances that do not allow coding for 97153.

FABA recommends:

- Modifier codes should be added to procedure 97153 so that appropriate rates can be billed when treatment must be implemented by a BCBA, BCBA-D or BCaBA.
- AHCA should include modifier codes that align with Medicaid regulations from other states, large insurance companies, and the recommendations of the AMA and the ABA CPT Billing coalition (see References).
- AHCA should apply the prior service authorization process to identify and authorize service delivery under 97153 with a modifier that reflects the qualifications of the professional providing the service. The prior authorization process can be used to identify services when RBT providers would be appropriate.
- The proposed implementation date is August 1, 2022. A more gradual transition of six months (or longer) would be appropriate for phasing out generally applicable modifiers for 97153 and allow for the continued use of modifiers based on individualized determination of need. The additional time would also be helpful so there can be more opportunities for public review and comments, plus sufficient advance notice so formal training can be completed before implementation. A more gradual transition period would also:
    - prevent disruption of services by allowing providers to recruit RBTs, reassign staff, and determine if they can absorb costs or must give fair notice to families that they will need to find new a provider
    - allow service recipients and families to find alternate providers when necessary

- allow time for eQHealth to:
    - develop standards and procedures for determining need for services by more qualified providers
    - develop standards and procedures for transitioning from current codes to CPT codes for current and new service authorizations. Examples:
        - the transition from some H codes to CPT codes could be difficult, including H2019 to 97153
        - code 97153 XP clarification (see page 2)
    - provide advance scheduling and delivery of formal training that is interactive so providers can ask questions for clarification (rather than an asynchronous webinar)
  - assure no delays or disruptions in reimbursement payments
- AHCA should delay the implementation date until the revised Behavior Analysis Service policy has been promulgated and training has been conducted

2 The prohibition of concurrent billing of 97153 and 97155 is not in accord with the generally accepted and recommended use of the AMA-approved 971 CPT codes and thus should be corrected to allow concurrent billing for these services.

- Other funders using CPT codes adhere to the recommendations provided by the AMA and ABA Coding Coalition which recognize the services encompassed by 97153 (direct treatment) and 97155 (protocol modification) are distinct services that are delivered at the same time and therefore are allowed and intended to be billed concurrently.
- Failure to follow CPT code guidance and compensate providers for related services may raise challenges about non-quantitative treatment limitation subject to prohibitions and protections of the Mental Health Parity and Addition Equity Act (see References). For example, it may be questioned if this restriction also applies to medical surgical conditions and treatment.
- Concurrent billing of 97155 with 97153 supports the process of RBTs receiving on-site supervision by a BCBA that is required to assure effective service provision and maintenance of their credentials.
- Medicaid plans in many states (see list in References), and many insurance providers do allow concurrent billing. Many of these other providers also provide a significantly higher rate. Maintaining a robust provider network for Medicaid recipients will require somewhat competitive compensation rates and allowances.

FABA recommends:

- The proposed fee schedule should be modified to allow concurrent billing so that a Lead Analyst and RBT or BCaBA can bill at the same time, when clinical direction is being provided.

Other concerns that have been raised include:

- It may be desirable for AHCA to add a location modifier so that an analysis could be conducted of environments in which services were being provided.
- Although FABA understands that the intent of the current rate proposal was not to increase rates, there is concern that the Medicaid rates remain lower than neighboring states and other insurance providers in Florida.

Again, FABA appreciates our working relationship with the Agency for Health Care Administration. We look forward to finding solutions to assure that effective and ethical behavior analysis services are available to all Florida Citizens.

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References:

American Medical Association CPT Assistant November 2018, Vol. 28, Issue 11, p. 5 ("Coding Tips")

ABA Coding Coalition FAQ, "Can I report 971 53 and 97155 concurrently?" - https://abacodes.org/frequently-asked-questions

AMA CPT Editorial Panel - https://abacodes.org/codes/

Model Coverage Policy and Supplemental Guidance - https://abacodes.org/resources/

Mental Health Parity and Addiction Equity Act (MHPAEA) as applied to state Medicaid programs. 42 C.F.R. §438.900 et seq.; see 81 Fed. Reg. 18411.

Seventeen states that allow for concurrent billing of 97153 and 97155:
1. Arizona
2. California
3. Colorado
4. Georgia
5. Iowa
6. Louisiana
7. Michigan
8. Minnesota
9. Nevada
10. New Mexico
11. North Carolina
12. Ohio
13. Rhode Island
14. South Carolina
15. Tennessee
16. Virginia
17. West Virginia