

**NC Medicaid
Research-Based
Behavioral Health Treatment (RB-BHT)
For Autism Spectrum Disorder (ASD)**

**Medicaid
Clinical Coverage Policy No: 8F
Amended Date: August 1, 2026**

To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

Table of Contents

1.0	Description of the Procedure, Product, or Service.....	1
1.1	Definitions	2
2.0	Eligibility Requirements	3
2.1	Provisions.....	3
2.1.1	General.....	3
2.1.2	Specific	3
2.2	Special Provisions.....	3
2.2.1	EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age	3
3.0	When the Procedure, Product, or Service Is Covered.....	4
3.1	General Criteria Covered.....	4
3.1.1	Telehealth Services.....	5
3.1.2	Telephonic Services.....	5
3.2	Specific Criteria Covered.....	7
3.2.1	Specific criteria covered by Medicaid	7
3.2.2	Medicaid Additional Criteria Covered.....	7
3.2.3	Provisional Diagnosis	7
3.2.4	Non-Provisional Diagnosis	7
3.2.5	Medical Necessity Criteria.....	8
3.2.6	Service Order.....	8
3.2.7	Continued Stay Criteria	9
3.2.8	Transition or Discharge Criteria	10
4.0	When the Procedure, Product, or Service Is Not Covered.....	11
4.1	General Criteria Not Covered	11
4.2	Specific Criteria Not Covered.....	11
4.2.1	Specific Criteria Not Covered by Medicaid.....	11
4.2.2	Medicaid Additional Criteria Not Covered.....	12
5.0	Requirements for and Limitations on Coverage	12
5.1	Prior Approval	12
5.1.1	Reauthorization.....	12
5.2	Prior Approval Requirements	13
5.2.1	General.....	13
5.2.2	Specific	13
5.3	Additional Limitations or Requirements	13
5.3.1	Assessment and Treatment Plan	13
5.3.2	Treatment Plan Development	14
5.3.3	Treatment Plan.....	15
5.3.3.1	Beneficiary Background Information and Case Conceptualization.....	15
5.3.3.2	Assessment of Data and Information.....	16

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5.3.3.3	Treatment Interventions, Scope, and Goals	16
5.3.3.4	Treatment Intensity	17
5.3.3.5	Service Schedule	17
5.3.3.6	Staffing	18
5.3.3.7	Titration Plan	18
5.3.3.8	Crisis Management Plan	18
5.3.3.9	Caregiver Involvement	19
5.3.4	Treatment Plan Reviews and Updates	20
5.4	Documentation Requirements	21
5.5	Responsibility for Documentation	21
5.5.1	Contents of a Service Note	21
6.0	Provider(s) Eligible to Bill for the Procedure, Product, or Service	22
6.1	Provider Qualifications and Occupational Licensing Entity Regulations	23
6.2	Provider Certifications	23
6.3	Provider Roles	24
6.3.1	Additional Provider Role Criteria	24
7.0	Additional Requirements	24
7.1	Compliance	24
7.2	Audits and Compliance Reviews	25
8.0	Policy Implementation and History	26
Attachment A:	Claims-Related Information	33
A.	Claim Type	33
B.	International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)	33
C.	Code(s)	33
C.1	Prior Approval and Authorization:	35
D.	Modifiers	36
E.	Billing Units	36
F.	Place of Service	36
G.	Co-payments	36
H.	Reimbursement	37
Attachment B:	Applied Behavior Analysis Service Definition	38
A.	Medicaid Billable Service	38
B.	Service Definition and Required Components	38
C.	Provider Requirements and Roles	38
D.	Provider types eligible to develop, modify, and supervise implementation of an ABA Treatment Plan	39
E.	ABA Rendering Providers	39

Related Clinical Coverage Policies

Refer to <https://medicaid.ncdhhs.gov/> for the related coverage policies listed below:

1-H: Telehealth, Virtual Patient Communications, and Remote Patient Monitoring.

1.0 Description of the Procedure, Product, or Service

Research-Based Behavioral Health Treatment (RB-BHT) is a research-based behavioral intervention service that demonstrates clinical efficacy in preventing or minimizing the disabilities and behavioral challenges associated with Autism Spectrum Disorder (ASD). This service promotes, to the extent practicable, adaptive functioning of the beneficiary.

RB-BHT services include the following:

- a. Behavioral, Adaptive or Functional Assessment and development of an individualized Treatment Plan;
- b. Delivery of RB-BHT services, including:
 1. Adapting the environment to promote positive behaviors and learning while reducing negative behaviors (antecedent based intervention, visual supports);
 2. Applying treatment procedures to change behaviors and promote learning (reinforcement, differential reinforcement of alternative behaviors, extinction);
 3. Teaching techniques to increase positive behaviors, build motivation, develop social skills, communication skills, and adaptive skills (discrete trial teaching, modeling, naturalistic intervention, social skills instruction, picture exchange communication systems, pivotal response training, social narratives, self-management, prompting);
 4. Using typically developing peers (a beneficiary who does not have ASD) to teach and interact with children with ASD (peer mediated instruction, structured play groups);
 5. Applying technological tools to change behaviors and teach skills (modeling, tablet-based learning software); and
 6. Training of parents, guardians, and caregivers on interventions consistent with the RB-BHT.
- c. Observation for modification of Intervention and Technician Direction must be provided when:
 1. the observing provider is in the same room or observing via telehealth in accordance with **subsection 3.1.1** as the provider delivering in-person treatment to the beneficiary; and
 2. the observation is for the benefit of the beneficiary. The observing provider delivers observation and direction regarding developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for each beneficiary. Observation and direction also inform any modifications needed to the methods to be implemented to support the accomplishment of outcomes in the Treatment Plan. Observation and direction must be provided on an ongoing basis throughout the time that RB-BHT services are being provided to a beneficiary. Refer to **subsection 6.3 Provider Roles and Attachment B**.

1.1 Definitions

Preventative

To anticipate the development of a disease or condition and preclude its occurrence.

Diagnostic

To examine specific symptoms and facts to understand or explain a condition.

Diagnosis

Is the identification of the nature of an illness or other problem by examination of the symptoms.

Therapeutic

To treat and cure disease or disorder; it may also preserve health.

Rehabilitative

To restore that which one has lost, to a normal or optimum state of health.

Caregivers

Caregiver in this policy refers to the following beneficiary(s): Parent(s) (as defined in 42 C.F.R. § 435.603(b)); Guardian(s)) (as defined in N.C G.S. § 108D-62(a)(5), Custodian(s)) (as defined in G.S. 7B-101, or a comparable tribal code); or Caretaker relative(s) (as defined in 42 C.F.R. § 435.4).

Provisional Diagnosis

Diagnosis for a beneficiary under three years of age that is determined by a licensed professional as provisional or “rule-out” based on significant concern for ASD (physician screening results, early intervention documentation of concern, or observation of symptoms in combination with Caregiver concern when a comprehensive evaluation has not yet been completed). Refer to **subsection 3.2.1** Specific Criteria Covered by Medicaid for diagnosing provider criteria.

Respite

Provides periodic support and temporary relief to the primary Caregiver(s) from the responsibility and stress of caring for a beneficiary. The service enables Caregiver(s) to meet or participate in planned or emergency events and to have planned time for themselves and/or family members.

Applied Behavior Analysis (ABA)

Evidence-based, validated, RB-BHT modality for the treatment of ASD that involves the analysis, design, implementation, and evaluation of social and environmental interventions to produce clinical outcomes and measurable changes in a beneficiary’s behavior.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(The term “General” found throughout this policy applies to all Medicaid policies)

- a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise)*.
- b. Provider(s) shall verify each Medicaid beneficiary’s eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.2 Specific

(The term “Specific” found throughout this policy only applies to this policy)

a. Medicaid

An applicant may be approved for Medicaid if the applicant meets all eligibility requirements. Occasionally, a beneficiary may become retroactively eligible for Medicaid while receiving covered services.

Retroactively an eligible beneficiary is entitled to receive Medicaid covered services and to be reimbursed by the provider for all money paid during the retroactive period except for any third-party payments or cost -sharing amounts. The qualified provider may file for reimbursement with Medicaid for these services. (Refer to 10A NCAC 22J.0106).

A Medicaid beneficiary, who meets the criteria in **Section 3.0** of this policy is eligible for Research Based - Behavioral Health Treatment for Autism Spectrum Disorder.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for a Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <https://medicaid.ncdhhs.gov/>

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;

- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.1.1 Telehealth Services

As outlined in **Attachment A**, select services within this clinical coverage policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance set forth in Clinical Coverage Policy 1-H: Telehealth, Virtual Patient Communications, and Remote Patient Monitoring.

3.1.2 Telephonic Services

Attachment A identifies selected services in this clinical coverage policy that can be provided via the telephonic, audio-only communication method. Telephonic services shall be transmitted between a patient and provider in a manner that is consistent with the Current Procedural Terminology (CPT) code and definition for those services.

When RB-BHT services are delivered telephonically the following criteria must be met:

- a. The provider shall ensure that services can be safely and effectively delivered using telephonic, audio-only communication;
- b. Providers shall consider the Caregivers' abilities to participate in services provided using telephonic, audio-only communication;
- c. The Caregivers' physical or behavioral health status prevents them from participating in in-person or telehealth services, or access issues (transportation, telehealth technology) prevent the Caregiver from participating in in-person or telehealth services;
- d. Delivery of services using telephonic, audio-only communication must conform to professional standards of care including but not limited to: ethical practice, scope of practice, and other relevant federal, state and institutional policies and requirements including Practice Act and North Carolina Licensing Board rules (N.C.G.S. § 90-270, N.C.G.S § 90731);
- e. Provider shall obtain and document verbal or written consent. In extenuating circumstances when consent is unable to be obtained, this shall be documented;
- f. Provider will verify the Caregivers' identity using two points of identification before initiating a telephonic, audio-only encounter. Providers shall verify Caregivers' identity through verification of the beneficiary's name and one of the following:
 - 1. Beneficiary Medicaid Identification number, or
 - 2. Beneficiary address.
- g. Providers shall ensure that the beneficiary and Caregivers' Protected Health Information (PHI) is protected.

Refer to **subsections 5.1, 5.2, and Attachment A** for Prior Approval requirements; and **subsection 7.1** for Compliance requirements.

3.1.3 Covered Modalities and Interventions

Covered RB-BHT modalities and interventions include but are not limited to the following examples, which have been supported by credible scientific or clinical evidence as appropriate for ASD:

- a. Applied Behavior Analysis (ABA);
- b. Early Start Denver Model (ESDM);
- c. Play and Language for Autistic Youngsters (PLAY) Project;
- d. Early Social Interaction (ESI);
- e. Pivotal Response Training (PRT);
- f. Improving Parents as Communication Teachers (ImPACT);
- g. Joint Attention Symbolic Play Engagement and Regulation (JASPER);
- h. Enhanced Milieu Teaching (EMT); or
- i. TEACCH Autism Program/Structured TEACHHing.

Attachment B, in this document includes requirements specific to delivery of Applied Behavior Analysis (ABA) services. Providers delivering ABA must comply with both the requirements in this policy and **Attachment B**.

To qualify under RB-BHT, the provider shall ensure the intervention is supported by credible scientific or clinical evidence, demonstrated by meeting one or more of the criteria listed below:

- a. Intervention is supported by at least two high quality experimental or quasi-experimental group design studies conducted by at least two different researchers or research groups;
- b. Intervention is supported by at least five high-quality single subject design studies conducted by three different investigators or research groups and having a total of at least 20 participants across studies;
- c. Intervention is supported by a combination of evidence that includes at least one high quality randomized or quasi-experimental group design study and at least three high-quality single subject design studies conducted by at least three different investigators or research groups (across the group and single subject design studies); or
- d. Interventions have a strong evidence base for American Indian youth or is a Promising Practice intervention that is culturally grounded and a community driven program that is supported by tribal communities.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

Medicaid shall cover RB-BHT when the beneficiary meets the following specific criteria:

- a. diagnosed with ASD utilizing a scientifically validated diagnostic tool, or tools, for diagnosis of ASD (refer to **subsection 3.2.3 and 3.2.4**);
- b. RB-BHT services shall not be initiated based solely on screening tools, educational determinations, or informal clinical impressions;
- c. any beneficiary under three years of age, at the time of initiating services, a provisional diagnosis of ASD is accepted; and
- d. beneficiary must have an ASD diagnosis within six months of the provisional diagnosis.

3.2.2 Medicaid Additional Criteria Covered

None Apply

3.2.3 Provisional Diagnosis

A provisional diagnosis of ASD is a diagnosis made as a rule-out based on significant concern for ASD (physician screening results, early intervention documentation of concern, or observation of symptoms in combination with Caregiver concern) when a comprehensive evaluation has not been completed.

A beneficiary must have an ASD diagnosis within six months of the provisional diagnosis. A provisional diagnosis may be made by a:

- a. Licensed Psychologist;
- b. Licensed Psychological Associate (with required supervision as defined by Article 18G of the North Carolina Psychology Practice Act);
- c. Physician [Medical Doctor (MD) or, Licensed Doctor of Osteopathic Medicine (DO)]; or
- d. Licensed clinicians with at least a master's degree who have completed the required training and supervision to administer scientifically validated diagnostic tools for ASD and for whom this service is within their scope of practice.

3.2.4 Non-Provisional Diagnosis

Non-provisional diagnoses must be made by a Licensed Psychologist (when a diagnosis of autism is within their experience and competence as defined by Article 18G of the Psychology Practice Act), Licensed Psychological Associate (with required supervision as defined by Article 18G of the North Carolina Psychology Practice Act), or physician (MD or DO) acting within their legal scope of practice under North Carolina law. Evaluations conducted by a Licensed School Psychologist that include any or all required testing to meet non-provisional diagnoses criteria may be used by an eligible provider to meet Clinical Coverage Policy diagnostic criteria if there is no clinical indication to repeat testing.

A non-provisional ASD diagnosis must be made using one of the following scientifically validated tools (or subsequent versions of these tools):

- a. Brief Observation of Symptoms of Autism (BOSA);
- b. Tele-ASD-Peds (TAP);
- c. Autism Diagnostic Observation Schedule, Second Edition (ADOS-2); or
- d. Childhood Autism Rating Scale, Second Edition (CARS2-ST and CARS2-HF).

3.2.5 Medical Necessity Criteria

Medicaid shall cover RB-BHT when medically necessary for a beneficiary with ASD. RB-BHT providers shall document a written assessment that reflects the following medical necessity criteria:

- a. the beneficiary has a current ASD diagnosis, consistent with requirements in **subsection 3.2.4** and recognized by the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) reflecting the need for treatment;
- b. for a beneficiary under three years of age at the time services are initiated, a provisional diagnosis of ASD, consistent with requirements in **subsection 3.2.3**, is accepted;
- c. the covered treatment type and treatment intensity (hours requested) being requested is medically necessary and is scientifically demonstrated to address adaptive functioning and prevent and minimize ASD-related disabilities and behavioral challenges (refer to **subsection 3.1.3**). Treatment must not be in excess of the beneficiary's needs;
- d. the service is indicated based on current psychological and other relevant assessments; that inform the Treatment Plan (refer to **subsection 5.3.1**);
- e. this service promotes the adaptive functioning of the beneficiary; and
- f. a less intensive, alternative treatment intervention is unlikely to be equally or more effective based upon NC community practice standards.

3.2.6 Service Order

A Licensed MD, Licensed DO, or Licensed Psychologist working within their scope of practice shall complete and sign a service order.

Each service order must be signed and dated by the authorizing professional and must indicate the date on which the service was ordered. A service order must be in place prior to or on the day that the service is initially provided (refer to **Attachment A, Codes** for more information on prior approval by CPT code).

The service order must be based on a Behavioral, Adaptive, or Functional Assessment of the beneficiary's needs and a Treatment Plan based on that Assessment (refer to **subsection 3.5.2** Assessment and Treatment Plan below for assessment requirements and **subsection 5.3.3**).

Service orders are valid for one year, which is distinct from the prior authorization period (refer to **subsection 5.1 Prior Approval** for more information). Medical necessity must be reconfirmed, and services must be ordered annually, based on the date of the original service order.

For the Eastern Band of Cherokee Indians, Service Orders are part of the Cherokee Indian Health Authority (CIHA) Electronic Health Record. These service orders will be maintained in accordance with current agreements reached with DHHS.

3.2.7 Continued Stay Criteria

Medicaid shall cover a continued stay if:

- a. The desired outcome or level of functioning is achievable using the services requested, but is not yet restored or improved; or
- b. The beneficiary continues to be at risk for regression based on current clinical assessment, history, or the tenuous nature of the functional gains, and the beneficiary meets one of the following conditions;
 1. has achieved current Treatment Plan goals and additional goals are indicated as evidenced by documented symptoms;
 2. is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the Treatment Plan;
 3. is making some progress, but the specific interventions, frequency, intensity, and location in the Treatment Plan need to be modified so that greater gains, which are consistent with the beneficiary's pre-morbid or potential level of functioning, are possible;
 4. fails to make progress or demonstrates regression in meeting goals through the interventions outlined in the Treatment Plan. (In this case, the beneficiary must be reassessed to identify any unrecognized co-occurring disorders or medical issues and treatment recommendations should be revised based on the findings). The treatment team shall also explore personnel changes and changes in RB-BHT modality; or
 5. is effectively functioning with this service and discharge would otherwise be indicated, however, regression is anticipated if the service is removed. The RB-BHT services must be maintained when it can be reasonably anticipated that regression is likely to occur if the service is reduced or removed. The decision must be based on either of the following:
 - A. there is documented history of regression in the absence of RB-BHT services, or attempts to titrate RB-BHT services downward have resulted in regression; or
 - B. there is a clinically sound expectation that the core and associated deficits of ASD persist and that ongoing treatment interventions are needed to sustain functional gains.

3.2.8 Transition or Discharge Criteria

The RB-BHT provider shall implement a treatment program transition or discharge plan when a beneficiary meets at least ONE of the following criteria:

- a. the individual responsible to consent to treatment for the beneficiary or beneficiary desires to discontinue services;
- b. the beneficiary who has a provisional diagnosis for ASD does not meet the diagnostic criteria for ASD (as measured by one of the required scientifically validated tools);
- c. the beneficiary and team determine that RB-BHT services are no longer needed based on the attainment of goals as identified in the titration plan as part of the Treatment Plan, no additional goals are needed, and a different level of care would adequately address current goals (refer to **subsection 5.3.3.7 Treatment Plan** for more information on the titration plan);
- d. the beneficiary and the treatment team determine that a different RB-BHT provider agency is needed to attain the goals as identified in the Treatment Plan;
- e. the beneficiary and the treatment team determine that a different RB-BHT treatment modality is needed to attain the goals as identified in the Treatment Plan;
- f. the beneficiary moves out of the catchment area, and the provider has facilitated the referral to either a new RB-BHT provider or other appropriate service in the new place of primary private residence and has assisted the beneficiary in the transition process;
- g. the beneficiary and, if appropriate, the individual responsible to consent to treatment for the beneficiary, chooses to withdraw from services and documented attempts by the program to re-engage the beneficiary with the service have not been successful; or
- h. the beneficiary is functioning effectively with this service and discharge is indicated. It is not anticipated that regression is likely to occur if the service is removed. The decision must be based on either of the following:
 1. the beneficiary does not have a documented history of regression in the absence of RB-BHT services, or attempts to titrate RB-BHT services downward have not resulted in regression; or
 2. there is not a clinically sound expectation that ongoing treatment interventions are needed to sustain functional gains; or
- i. the beneficiary has not demonstrated significant improvement following reassessment and reasonable adjustments to the Treatment Plan, personnel or modality over at least 180 calendar days and:
 1. alternative treatment or providers have been identified that are deemed necessary and are expected to result in greater improvement;
 2. the beneficiary's core and associated deficits have worsened, such that continued treatment is not anticipated to result in sustainable change; or
 3. the beneficiary is not appropriate for the service type.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid

Medicaid shall not cover the following under RB-BHT activities, and these activities are not allowed or considered an activity for RB-BHT services:

- a. time spent on the beneficiary's activities that are not explicitly part of a goal in the approved Treatment Plan (recreational activities, meals, naps, transportation time, and breaks);
- b. services teaching academic subjects or as a substitute for educational personnel, including a teacher, teacher's aide or an academic tutor;
- c. childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision;
- d. custodial or respite care;
- e. Services primarily intended to provide direct assistance with activities of daily living (ADLs) or instrumental ADLs (iADLs) (personal care services);
- f. covered services that have not been rendered;
- g. services not identified on the beneficiary's authorized Treatment Plan;
- h. services provided without prior authorization by the PHP;
- i. services provided to children, spouse, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary's life to address problems not directly related to the eligible beneficiary's issues and not included in the eligible beneficiary's Treatment Plan;
- j. services that are not based in credible scientific or clinical evidence;
- k. services available through the Individuals with Disabilities Education Act (IDEA) or other educational programs that are duplicative of or supplant services identified in the beneficiary's authorized Treatment Plan;
- l. staff-only meetings and trainings where the beneficiary or Caregiver are not present;
- m. administrative and documentation-related tasks, with the exception of clinically appropriate, treatment-concurrent documentation, and where non-face-to-face documentation and treatment plan development are permitted by the 97151 CPT code;

- n. non-RB-BHT Medicaid services billed at the same time as RB-BHT service (as reflected in the session note, See subsection 5.5.1 contents of a Service Note). Same-day delivery is allowable; or
- o. any service not covered in Section 3.0 of this policy.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

Medicaid shall require prior approval for Research-Based Behavioral Health Treatment services. The provider shall obtain prior approval before rendering Research-Based Behavioral Health Treatment services. Prior approval is based on review of a beneficiary's Treatment Plan at the time of authorization request (refer to **subsection 5.3.4** for Treatment Plan Reviews and Updates requirements) and the assessment used to inform the Treatment Plan (refer to **subsection 5.3.1** for assessment requirements).

RB-BHT services are provided under a prior authorized Treatment Plan that has measurable goals over a specific timeline for the specific beneficiary being treated as developed by a Licensed Qualified Autism Service Provider (LQASP). Services provided without prior authorization are not considered for payment or reimbursement except in the case of retroactive Medicaid eligibility.

For Treatment Plans involving 16 hours or fewer services per week per beneficiary, Medicaid covers up to 180-calendar days for the initial authorization period based on medical necessity documented on the authorization request form and supporting documentation.

For Treatment Plans involving more than 16 hours of services per week, Medicaid covers up to 90 calendar days for the initial authorization period based on medical necessity documented on the authorization request form and supporting documentation, which must be reviewed, modified, and submitted for reauthorization.

5.1.1 Reauthorization

Extension of service authorization must be received to continue coverage of the service. An authorized Treatment Plan involving 16 hours or fewer of services per week must be reviewed, modified, and submitted for reauthorization at least once every 180-calendar days. An authorized Treatment Plan involving more than 16 hours of services per week must be reviewed, modified, and submitted for reauthorization at least once every 90 calendar days.

Medicaid reauthorization is based on the medical necessity documented in the Treatment Plan, the authorization request form, and supporting documentation. Reauthorization must be submitted prior to initial or concurrent authorization expiring.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

- a. the prior approval request; and
- b. all health records and any other records that support the beneficiary has met the specific criteria in **subsection 3.2** of this policy.

5.2.2 Specific

Utilization Management of covered services is a part of the assurance of medically necessary service provision. Authorization, which is an aspect of utilization management, validates approval to provide a medically necessary covered service to eligible beneficiary.

For Eastern Band of Cherokee Indian members, prior approval and utilization management functions have been delegated by the Division of Health Benefits to the Cherokee Indian Health Authority (CIHA).

5.3 Additional Limitations or Requirements

5.3.1 Assessment and Treatment Plan

Each RB-BHT service beneficiary shall receive all required assessments prior to the initial authorization for behavioral treatment services and as indicated, for reauthorization of services. (refer to **subsection 5.1** for service authorization requirements). Assessments shall:

- a. be based on the beneficiary's strengths and interests; and
- b. describe the core and associated deficits of ASD for the beneficiary and how those deficits impact the beneficiary.

The provider shall submit the following assessments and supporting information for each beneficiary, as clinically indicated for the covered RB-BHT modalities and interventions being delivered. The results of the assessment(s) must be used to inform the Treatment Plan development, including the type of treatment modality and scope of treatment to be delivered, and intensity of the treatment delivered (number of service hours per week).

Required assessments include:

- a. A skills assessment to guide the development of objectives, treatment planning, and measurement of progress, using one of the following scientifically validated tools:
 1. Verbal Behavior Milestones Assessment and Placement Program;
 2. Assessment of Basic Language and Learning Skills-Revised; or

3. ESDM Curriculum Checklist.
- b. A functional behavior assessment or, at provider option, a functional behavioral analysis when the challenging behaviors are present and being addressed;
- c. Documentation of relevant family or other Caregiver resources, stressors, strengths, and goals within Treatment Plan;
- d. At least one of the following adaptive behavior assessments completed within the last 3 years for the beneficiary: Vineland Adaptive Behavior Scales, Third Edition (VABS-3), Adaptive Behavior Assessment System, Third Edition (ABAS-3), Developmental Profile 4 (DP-4); or subsequent editions of these tools;
- e. Developmental and medical history (as available and relevant), including beneficiary's age, developmental milestones, biopsychosocial history, functional abilities, presence of any co-occurring medical, psychiatric, or genetic conditions, history of services received, and response to current or prior treatments;
- f. Available and relevant supplementary information including interviews, chart reviews, and observation notes; and
- g. Intake or interview that identifies any available and relevant supplementary information including those identified through chart reviews and observation notes.

Note: Providers may substitute an alternative assessment tool with a clinical justification in the event that required instruments are not clinically indicated for the beneficiary.

5.3.2 Treatment Plan Development

All RB-BHT Services must be provided and supervised under an approved Treatment Plan developed by an LQASP (see Attachment B for more information on ABA providers who can develop the treatment plan). Coverage is limited to medically necessary services.

An LQASP is a person who meets ONE of the following credentials:

- a. Licensed as a physician (MD or DO);
- b. Licensed Psychologist;
- c. Licensed Psychological Associate (with required supervision as defined by Article 18G of the North Carolina Psychology Practice Act);
- d. Licensed occupational therapist;
- e. Licensed speech-language pathologist;
- f. Licensed clinical social worker;
- g. Licensed clinical mental health counselor;
- h. Licensed marriage and family therapist;
- i. Licensed behavior analyst as defined under N.C. General Statute §90-732(7);
or

- j. Other licensees are allowed to independently practice RB-BHT under the licensee's scope of practice permitted in North Carolina, provided the services are within the experience and competence of the state licensee.

Note: According to 25 U.S.C. 1621, licensed health professionals employed by a tribal health program are exempt, if licensed in any state, from the licensing requirements of the State (North Carolina) in which the tribal health program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

5.3.3 Treatment Plan

All RB-BHT services require a Treatment Plan (unless otherwise specified below). The Treatment Plan must be signed and dated by the LQASP responsible for the Treatment Plan and the individual responsible for consenting to treatment for the beneficiary (refer to **Section 1.1 Definitions**) prior to delivery of services.

The provider responsible for the Treatment Plan must share information and coordinate with the beneficiary's primary care providers(s) and other providers on the beneficiary's care team (as applicable), with all legally required consent.

The Treatment Plan must meet all of the following criteria:

- a. The Treatment Plan must be person-centered, developmentally appropriate, and individualized to the beneficiary's strengths, functional impairments, and adaptive skill levels;
- b. The Treatment Plan must not include default recommended service hours. Recommended treatment dosage must reflect the behavioral support needs of each beneficiary. Providers shall not apply uniform minimum thresholds across all beneficiaries regardless of beneficiary clinical need; and
- c. Providers shall offer a beneficiary a range of hours in the Treatment Plan. Providers shall not require a beneficiary to receive a minimum number of hours in order to access treatment unless clinically necessary to make progress against goals in the authorized Treatment Plan.

The Treatment Plan must include all of the required elements described below, unless those elements have already been obtained through a formal assessment. When any required element listed below is not included in the treatment plan, the provider shall submit written justification for its exclusion.

5.3.3.1 Beneficiary Background Information and Case Conceptualization

The Treatment Plan must include the following elements:

- a. The beneficiary's age;
- b. Beneficiary's diagnosis (ASD and any co-occurring medical conditions, including mental health and substance use disorders);
- c. Referring provider and referring provider's agency; and referral reason (including presenting concerns of the patient and family);

- d. Beneficiary's behavioral or developmental skills and challenges to be treated;
- e. Frequency, intensity, and social significance of challenging behaviors;
- f. Beneficiary's biopsychosocial history, including family structure (as applicable), social support systems, medications (with prescriber), school placement, and Individualized Education Plan or Individualized Family Service Plan status;
- g. Environmental factors that may inform the beneficiary's treatment, including neighborhood and community resources;
- h. Potential barriers to full participation by the beneficiary in treatment and corresponding solutions;
- i. History of services received by the beneficiary and current services (outpatient therapy, occupational therapy, school-based services); and
- j. File review of previous and concurrent treatment assessments, approaches, services, and evaluations;

5.3.3.2 Assessment of Data and Information

Treatment plans must include assessments and information specified in specified in **subsection 5.3.1**.

5.3.3.3 Treatment Interventions, Scope, and Goals

- a. Treatment Plan must include treatment interventions specified in **subsection 3.1.3** (the research-based models or modalities) that will be used.
- b. Scope of treatment (focused or comprehensive, according to the guidelines below), as relevant to the specific modality:
 - 1. Focused scope of treatment: Treatment to improve or maintain behaviors in a limited number of domains or skill areas.
 - 2. Comprehensive scope of treatment: To improve or maintain behaviors in many skill areas across multiple domains (cognitive, social, behavioral, adaptive).
- c. Defined, measurable treatment goals with current baselines and measurement methods for each goal, including starting points, progress milestones and target dates, and intervals for frequency of measurement;
- d. Goals must be specific, behaviorally defined, tied to developmental improvements, measurable, and based upon clinical observation;
- e. Goals must be updated when the treatment goals and objectives are achieved or no longer appropriate;
- f. Goals must identify the Caregivers' priorities across home, school, and community settings and include Caregiver training objectives to promote generalization and maintenance of skills (see below **subsection 5.3.3.9** for requirements specific to Caregiver training);

- g. Outcome measurement assessment criteria that will be used to measure achievement of treatment objectives and goals;
- h. Frequency at which the beneficiary's progress is evaluated and reported;
- i. Behavior reduction and acquisition procedures, including the conditions under which behavior is to be demonstrated, and improvement criteria achieved, to include the date of introduction, estimated date of targeted improvement, and a plan for generalization of skill(s); and
- j. Location of the service and treatment settings (home, school, community, outpatient clinic, or residential).

5.3.3.4 Treatment Intensity

Providers shall ensure that treatment intensity considers opportunities for unstructured or non-therapeutic time needed for meals, snacks, hydration, toileting, and rest or naps, as clinically appropriate for the beneficiary's age and individual needs.

The Treatment Plan **must** include treatment intensity by identifying the following:

- a. The number of hours of direct service, observation and direction not including case supervision, Caregiver training, and non-billable services as described in Attachment A, C. Codes. Providers shall indicate which activities will be performed by a paraprofessional.
- b. Hours spent in educational settings and receiving Individualized Education Program services should not be included in the calculation of treatment hours.
- c. The targeted ratio of observation with protocol modification to adaptive behavior treatment. Refer to Attachment A, for additional requirements.
- d. Clinical justification for service intensity that includes how service hours will be used. Treatment must not be in excess of the beneficiary's needs.
- e. Clinical justification for each service location identified in the Treatment Plan as the most appropriate for the beneficiary based on the beneficiary's individual needs and goals.
- f. If applicable, clinical justification for use of telehealth or telephone.

5.3.3.5 Service Schedule

Treatment Plans requesting more than 16 hours of service per week per beneficiary shall include a schedule of services that identifies the:

- a. Anticipated, typical weekly service schedule for all Medicaid-covered and non-Medicaid covered services the beneficiary receives or will receive on a regular/ongoing basis, not limited to services and supports for ASD and ASD-related symptoms;

- b. The typical service schedule must include the following, if received by the beneficiary:
 1. RB-BHT services;
 2. School-based services, and school schedule, including full-day partial-day, home hospital, etc.;
 3. Respite services;
 4. Outpatient specialized therapies (occupational therapy, physical therapy, speech and language therapy);
 5. Social skills training; and
 6. Other therapeutic or habilitative services related to skills acquisition or capacity building.

5.3.3.6 Staffing

The Treatment Plan must identify by name all providers responsible for the delivery of services. Paraprofessionals may be identified by role and title in the Treatment Plan.

Providers shall maintain a list of all paraprofessionals involved in service provision for each beneficiary to be made available upon request to the beneficiary's health plan (for submission to support request for reauthorization). Staffing changes require the individual responsible to consent to treatment for the beneficiary, as applicable.

5.3.3.7 Titration Plan

The Treatment Plan must include a titration plan. The titration plan shall:

- a. Contemplate appropriate reduction in service intensity and generalization of skills across settings; and transition to natural and other paid supports (as needed, including any training needed) (Refer to **subsection 3.2.6** for more information on requirements related to transition or discharge that inform the titration plan);
- b. Consider Caregiver(s)' involvement required to modify/reduce service intensity; and
- c. Be in place at the start of treatment and modified as indicated based upon progress.

5.3.3.8 Crisis Management Plan

Providers shall include a crisis management plan in the Treatment Plan, as applicable. A crisis management plan must include early warning signs and triggers; prevention and response strategies, involving both formal and natural supports; preferred communication methods and emergency contacts; a post-crisis follow-up; and a debriefing process for plan review and updates. The crisis management plan should not be duplicative to existing care management crisis plans. If a beneficiary does not require a crisis management plan, the provider shall provide clinical justification.

5.3.3.9 Caregiver Involvement

- a. The provider responsible for the Treatment Plan must share the Treatment Plan with, at a minimum, the individual responsible to consent to treatment for the beneficiary (refer to **subsection 1.1**) with all legally required consent.
- b. The provider shall share information with the individual responsible for consenting to treatment for the beneficiary, including the risks, benefits, indications and potential alternatives to the treatment modalities and interventions listed in the Treatment Plan. Information must be sufficient to inform the individual responsible to consent to treatment for the beneficiary (**refer to subsection 1.1**).
- c. The provider shall involve Caregivers in assessment and treatment unless clinically contraindicated and documented. The Treatment Plan must reflect meaningful Caregiver engagement. A provider shall provide a justification in circumstances when the Caregiver(s) cannot or choose(s) not to participate in training/treatment; and identify alternative person(s) who can support implementation of the Treatment Plan.
- d. The Treatment Plan must include a list of the beneficiary's Caregiver(s), indicating which are primary (refer to **subsection 1.1** for the definition).
- e. The Treatment Plan must include at least two specific and measurable Caregiver goals. At least one specific, measurable goal must be tied directly to how the primary Caregiver(s) will support delivery of services to reduce maladaptive behaviors or build functional skills in the beneficiary.

5.3.3.9.1 Caregiver Goal

Each Caregiver goal must include the following elements:

- a. Baseline data (as applicable);
- b. Behavior the Caregiver(s) is/are expected to demonstrate;
- c. Mastery criteria that specify the conditions under which the Caregiver(s) must demonstrate a skill (during a specific routine or without prompting from a therapist);
- d. Timelines; and
- e. Caregiver-identified priorities across home, school, and community settings.

5.3.3.9.2 Caregiver Involvement

The Caregiver involvement and training plan shall, include the following:

- a. Training procedures, to include how the following aspects of Caregiver training will be conducted, as applicable;

- b. Schedule of a minimum of six Caregiver training sessions that must be completed per the 180-calendar day authorization period. Caregiver training sessions must be conducted in alignment with goals in the Treatment Plan and billing requirements for CPT codes 97156 and 97157;
- c. A provider shall submit written justification in the Treatment Plan if Caregiver training is not incorporated or the number of training hours and/or goals are below the required minimum, including documented efforts to engage the Caregiver in treatment;
- d. Instructional content tailored to beneficiary needs;
- e. Skill demonstration through guided examples;
- f. Hands-on practice for each skill with real-time support or, continued supports, including ongoing oversight and coaching, collaborative problem solving, promoting generalization and maintenance of skills, and assistance with applying strategies across new settings;
- g. A barrier analysis (indicating potential barriers to Caregiver involvement and a plan to address these barriers);
- h. A plan for generalization of skills across settings; and
- i. As appropriate, a plan for engaging other individuals who provide care or support to the beneficiary on a regular basis (school staff, residential staff).

5.3.4 Treatment Plan Reviews and Updates

At a minimum, the Treatment Plan must be reviewed by the responsible professional (refer to **subsection 6.3. Provider Roles and Attachment B**, for information on providers who are responsible for reviewing the Treatment Plan) based upon the following:

- a. Target date or expiration of each goal. Each goal in the Treatment Plan must be reviewed separately, based on the target date associated with it. Short-range goals in the Treatment Plan may never exceed 12 months from the date of plan;
- b. Change in the beneficiary's needs;
- c. Change in service provider; and
- d. Addition of a new service.

5.4 Documentation Requirements

The service record documents the nature and course of a beneficiary's progress in treatment. To request payment from Medicaid, providers shall ensure that their documentation is consistent with the requirements contained in this policy.

5.5 Responsibility for Documentation

The staff member who provides the service is responsible for accurately documenting the services billed to and reimbursed by Medicaid:

- a. The staff person who provides the service shall sign the written entry. The signature must document credentials (professionals) or a job title (paraprofessional).
- b. A Licensed Qualified Autism Service Provider Professional (LQASP) and Certified Qualified Professional (C-QP) are not required to countersign service notes written by a staff person who does not have LQASP or C-QP status.

5.5.1 Contents of a Service Note

More than one intervention, activity, or goal may be reported in one service note, if applicable. For this service, one of the documentation requirements is a full service note for each contact or intervention for each date of service, written and signed by the person(s) who provided the service. The service note must include the following:

- a. Beneficiary's name;
- b. Medicaid identification number;
- c. Date of service provision;
- d. Name of service provided;
- e. Type of contact;
- f. Place of service;
- g. Purpose of the contract as it relates to the goal(s) in the Treatment Plan;
- h. Description of the intervention provided/ services furnished. Documentation of the intervention must accurately reflect treatment for the duration of time indicated;
- i. A plan of care or treatment protocol modification was made (applicable only to service notes for CPT code 97155);
- j. Duration of service (Amount of time spent performing the intervention, including session time in/out);
- k. Assessment of the effectiveness of the intervention and the beneficiary's progress towards the beneficiary's goal, including any data collected; Providers delivering direct services to the beneficiary may document objective observation, treatment responses, and data collected during the session. Overall assessment of progress toward treatment goals remains the responsibility of the observing provider;
- l. (As applicable only to the service notes including CPT codes 97156 and 97157), whether training was provided to one or more Caregivers for a single or multiple beneficiaries with or without the beneficiary present,

- including specific guidance provided to families to implement treatment (not general discussion);
- m. Caregiver(s) present;
- n. Signature, date, and credentials or job title of the staff member who provided the service; and
- o. Each service note page must be identified with the beneficiary's name, Medicaid identification number, and record number.

A provider shall verify and maintain documentation of a qualifying ASD diagnosis prior to initiating RB-BHT services. Services rendered without adequate diagnostic documentation may be subject to service denial, recoupment, or termination of services.

5.5.1.2 Discharge or Transition

Documentation of discharge or transition to lower levels of care must report the following:

- a. Reasons for discharge or transition as stated by both the beneficiary and the RB-BHT Team;
- b. Beneficiary's status at discharge or transition;
- c. Written final evaluation summary of the beneficiary's progress toward the goals set forth in the Treatment Plan;
- d. A plan for follow-up treatment, developed in conjunction with the beneficiary;
- e. Signatures of the beneficiary or the individual responsible to consent to treatment for the beneficiary, and the developer of the Treatment Plan (LQASP); and
- f. A completed Consumer Admission and Discharge Form must be submitted to the health plan.

Note: Any denial, reduction, suspension, or termination of service by the State or State's vendor requires notification to the beneficiary or legal guardian about their appeal rights.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

Staff shall obtain licensure or certification according to N.C. General Statutes and practice within the scope of practice as defined by the individual practice board. The following types of staff are recognized as a LQASP:

- a. Physician (MD or DO);
- b. Licensed Psychologist;
- c. Licensed Psychological Associate (with required supervision as defined by Article 18G of the North Carolina Psychology Practice Act);
- d. Occupational Therapist;
- e. Speech and Language Pathologist;
- f. Licensed Clinical Social Worker;
- g. Licensed Clinical Mental Health Counselor;
- h. Licensed Marriage and Family Therapist;
- i. Licensed Behavior Analyst; and
- j. Other licenses allowed to independently practice RB-BHT under the scope of practice permitted in North Carolina, provided the services are within the experience and competence of the state license.

Staff shall obtain licensure or certification according to N.C. General Statutes and practice within the scope of practice as defined by the individual practice board.

A Certified Qualified Professional is a certified or provisionally licensed professional who is not licensed to practice independently but who otherwise meets the requirements to supervise paraprofessionals.

A paraprofessional is a person who has completed specific competency-based RB-BHT training for persons with ASD that is equivalent to the minimum hour requirements of the lowest level paraprofessional (Technician) as specified by the Behavior Analyst Certification Board (BACB). Refer to **Attachment B** for requirements specific to behavior technicians providing ABA services.

6.2 Provider Certifications

Competencies of LQASPs and C-QPs are documented along with supervision requirements to maintain that competency (10A NCAC 27G.0203).

Competencies and supervision of both paraprofessionals and Certified Qualified Professionals are documented along with supervision requirements to maintain that competency (10A NCAC 27G .0204).

Refer to **Attachment B**, for requirements specific to providers of ABA services.

6.3 Provider Roles

RB-BHT services are provided by a LQASP, C-QP or a paraprofessional (**Refer to Attachment B**) these rendering providers shall provide RB-BHT services as follows:

- a. A LQASP develops and modifies the Treatment Plan and may also supervise, observe, or provide RB-BHT services. The LQASP also completes the behavioral, functional or adaptive assessment(s). At least ten percent (10%) of all services under CCP-8F that are provided by a paraprofessional must involve the observation and direction of the paraprofessional by a LQASP.
- b. A C-QP provides, supervises, or provides and supervises RB-BHT pursuant to a Treatment Plan developed by a LQASP.
- c. A paraprofessional provides RB-BHT services pursuant to a Treatment Plan developed by a LQASP and be supervised or observed to modify behavior interventions by a LQASP or C-QP.

6.3.1 Additional Provider Role Criteria

In addition to the provider roles in **Section 6.0** above, the provider(s) shall:

- a. Meet the provider qualification policies, procedures, and standards established by the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS);
- b. Fulfill the requirements of 10A NCAC 27G;
- c. Demonstrate that they meet these standards;
- d. Become established as a legally constituted entity capable of meeting all the requirements of the Provider Certification, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards.

Note: According to 25 U.S.C. 1621t, licensed health professionals employed by a tribal health program are exempt, if licensed in any state, from the licensing requirements of the State (North Carolina) in which the tribal health program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and

- b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

7.2 Audits and Compliance Reviews

DMH/DD/SAS and DHB (DHHS team) jointly conduct annual audits of a sample of Medicaid funded mental health, developmental disabilities, and substance abuse services. The purpose of the audit is to ensure that these services are provided to Medicaid beneficiary according to federal and state regulations and that the documentation and billing practices of directly enrolled providers demonstrate accuracy and integrity. It is a quality control process used to ensure that medical necessity has been determined and to monitor the quality of the documentation of services provided. The health plan may also conduct compliance reviews and monitor provider organizations under the authority of DHB. Tribal providers are not subject to health plan audits.

Any deficiencies identified in an audit are forwarded to DHB's Program Integrity Section, along with the following information:

- a. A report of findings that summarizes the issues identified;
- b. Time period covered by the review;
- c. Type of sampling, and
- d. Copies of supporting documentation, showing the specific billing errors identified in the audit and reporting the beneficiary's name, Medicaid identification number, date(s) of service, procedure code, number of units billed in error, and reason for error.

Refunds or request for withholding from future payments must be sent to:
Office of Controller
DHB Accounts Receivable
2022 Mail Service Center
Raleigh, NC 27699-2022

8.0 Policy Implementation and History

Original Effective Date: Month Day, Year

History:

Date	Section or Subsection Amended	Change
08/15/2019	All Sections and Attachment(s)	New policy documenting current coverage for Research-Based Behavioral Health Treatment, for Medicaid and NCHC beneficiary under 21 years of age diagnosed with Autism Spectrum Disorder.
12/15/2019	Attachment A	Added: Note: Providers using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–5) manual shall submit claims using the ICD-10 diagnosis code that corresponds to the chosen DC:0-5 diagnosis.
12/15/2019	Table of Contents	Updated policy template language, “To all beneficiary enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.”
12/15/2019	Attachment A	Added, “Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
12/01/2020	Related Clinical Coverage Policies	1-H, Telehealth, Virtual Patient Communications, and Remote Patient Monitoring
12/01/2020	Section 3.1.1	Added new subsection 3.1.1 Telehealth Services.
12/01/2020	Section 3.1.2	Added new subsection 3.1.2 Telephonic Services
12/01/2020	Section 3.2.5	Added new subsection 3.2.2 Telephonic-Specific Criteria
12/01/2020	Subsection 6.1	Added: “Licensed Clinical Mental Health Counselor (LCMH)” Added: “Note: To comply with the NC General Assembly Session Law 2019-240 Senate Bill 537, licensure name for Licensed Professional Counselor (LPC) is amended to Licensed Clinical Mental Health Counselor (LCMHC) and Licensed Professional Counselor Associate (LPCA) is amended to Licensed Clinical Mental Health Counselor Associate (LCMHCA). Policy amendment(s) will be effective the date the related rule change for 10A NCAC 27G is finalized.”
12/01/2020	Attachment A, Section C	Added columns to service codes indicating if the services were eligible for telehealth. Added Columns to service codes indicating if the services are available

Date	Section or Subsection Amended	Change
		telephonically. Added “Note: Telehealth and telephonic eligible services may be provided to both new and established beneficiary by the eligible providers listed within this policy.”
12/01/2020	Attachment A, Section D	Added: Non-Telehealth Claims Added: Telehealth Claims: Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not appropriate for virtual patient communications or remote patient monitoring. Added: Telephonic Claims: Modifier KX must be appended to the CPT or HCPCS code to indicate that a service has been provide via telephonic, audio-only (telephonic services).
12/01/2020	Attachment A, Section F	Added: Telehealth and telephonic claims should be filed with the provider’s usual place of service code(s).
12/01/2020	Added beginning of Policy	Added the language “This clinical coverage policy has an effective date of November 15, 2020; however, until the end of the public health emergency, the temporary coverage and reimbursement flexibilities enabled by NC Medicaid through a series of COVID-19 Special Medicaid Bulletins will remain in effect.”
4/15/2023	All Sections and Attachment(s)	Updated policy template language due to North Carolina Health Choice Program’s move to Medicaid. Policy posted 4/15/2023 with an effective date of 4/1/2023.
08/01/2026	All Sections and Attachment(s)	Updated policy to reflect template language and grammatical updates
08/01/2026	Section 1.0	Redefined Research-Based Behavioral Health Treatment (RB-BHT) description. added Specific criteria for an intervention to be considered credible scientific or clinical evidence added examples of covered RB-BHT services replaced "Observation and Directing: Provider's observation and direction of the Paraprofessional (Board Certified Assistant Behavior Analysis or Technician, which is allowed only when" with "Observation and Direction: is allowed only when”:

Date	Section or Subsection Amended	Change
		Added "Refer to sub section 6.13 Provider Roles and Attachment B" replaced "paraprofessional" (BCaBA or technician) with "provider"
08/01/2026	Subsection 1.1	Removed initial language that references, "Preventative, Diagnostic, Therapeutic, and Rehabilitative in sentences and added "To" added definition for Caregivers added definition for Respite added definition for Applied Behavior Analysis (ABA) Replaced "professional" with "provisional" in Provisional Diagnosis definition added definition for Applied Behavioral Analysis (ABA)
08/01/2026	Subsection 2.1.2	removed "under 21 years of age"
08/01/2026	Subsection 3.1.2	added services that may be provided telephonically and criteria when RB-BHT services are delivered removed all language describing "One of the Following (i. and ii) removed "Refer to Subsection 3.2.5 for Telephonic Specific Criteria"
08/01/2026	Subsection 3.1.3	Updated description for Covered Modalities and Interventions added examples of Covered Modalities (a-i) added language to add Attachment B reference and qualifiers under RB-BHT (a-d)
08/01/2026	Subsection 3.2	Added new subsections and language: 3.2.3 Provisional Diagnosis, 3.2.4 Non-Provisional Diagnosis, 3.2.5 Medical Necessity Criteria and 3.2.6 Service Orders Updated the following subsections: 3.2.3 Continued stay moved to subsection 3.2.7 Service Order language moved to subsection 3.2.6

Date	Section or Subsection Amended	Change
08/01/2026	Subsection 3.2.1	Updated language for clarity
08/01/2026	Subsection 3.2.2	Removed Initial Process and Service Order Added "None Apply"
08/01/2026	Subsection 3.2.3	Updated subsection to: "Provisional Diagnosis" and added new provisional diagnosis language Moved Continued Stay criteria language subsection 3.2.7
08/01/2026	Subsection 3.2.4	Updated subsection to "Non-Provisional Diagnosis" and added new language and criteria for non-provisional diagnosis Moved Transition or Discharge Criteria to subsection 3.2.8
08/01/2026	Subsection 3.2.5	Updated this section from Telephonic-Specific Criteria now 3.1.2 to Medical Necessity Criteria to include clarification and reference to subsections. updated
08/01/2026	Subsection 3.2.6	Added new subsection titled Service Order, language updated to reflect the following: added requirement for RB-BHT provider to implement treatment program transition or discharge plan removed Telephonic Specific Criteria
08/01/2026	Subsection 3.2.7	Clarified language in criteria (a)
08/01/2026	Subsection 3.2.8	Clarified and updated Transition and Discharge Criteria. Transitioned Telephonic-Specific Criteria to subsection 3.1.2. language
08/01/2026	Subsection 4.2.1	added non-therapy or unstructured time and examples removed "planned social skill training or other therapeutic interventions" removed "respite care" replaced with "custodial, respite, or habilitative services" added the following language: "services available through the Individuals with Disabilities Education Act (IDEA) or other educational programs that are duplicative of or supplant services identified in the beneficiary's authorized Treatment Plan;

Date	Section or Subsection Amended	Change
		; Staff-only meetings and training; Administrative tasks and documentation; or any service not covered in Section 3.0 of this policy.”
08/01/2026	Subsection 5.1	Added language stating prior approval is based on review of beneficiary's Treatment Plan additional language added regarding extension of service authorization Added new prior approval requirements per Session Law2026-1 House Bill 696. Revised Reauthorization description
08/01/2026	Subsection 5.2.2	Removed paragraph language referencing under and over three years of age
08/01/2026	Subsection 5.3.1	Added new requirements for assessments and supporting information for beneficiary Added note to reference when providers may substitute an alternative assessment tool
08/01/2026	Subsection 5.3.2	Updated description for Treatment Plan Development Added “licensed” to all applicable LQASP’s Added Note to reference 25 U.S.C. 1621
08/01/2026	Subsection 5.3.3	Updated description for Treatment Plan Added provider requirements for the Treatment Plan Added required Treatment Plan criteria Removed treatment plan elements section including (a-g) Added the following new subsections: • Subsection 5.3.3.1 Added new section for Beneficiary Background Information and Case Conceptualization • Subsection 5.3.3.2 Added new section for Assessment of Data and Information • Subsection 5.3.3.3 Added new section for Treatment Interventions, Scope, and Goals requirements

Date	Section or Subsection Amended	Change
		• Subsection 5.3.3.4 Added new section for Treatment Intensity requirements • Subsection 5.3.3.5 Added new section for Service Schedule requirements • Subsection 5.3.3.6 Added new section for Staffing requirements • Subsection 5.3.3.7 Added new section for Titration Plan requirements • Subsection 5.3.3.8 Added new section for Crisis Management Plan requirements • Subsection 5.3.3.9 Added new section for Caregiver Involvement requirements • 5.3.3.9.1 Caregiver Goal • 5.3.3.9.2 Caregiver Involvement
08/01/2026	Subsection 5.3.4	Revised title to remove “Annual Rewriting” and added “Updates” Revised the Treatment Plan Reviews and Updates description
08/01/2026	Subsection 5.5.1	Added a subsection to Table of Contents to reference “Contents of a Service Note” Revised service note requirements Added “Caregiver(s) present Added language for documentation verification requirements for providers
08/01/2026	Subsection 6.1	Revised language and added additional providers that are recognized as a LQASP. Added language to add definition requirements per N.C. General Statute § 90-732(6).
08/01/2026	Subsection 6.2	Revised provider certification description to add “LQAPs” and “C-QPs”
08/01/2026	Subsection 6.3	Updated and provided clarity to provider roles
08/01/2026	Attachment A: Claims-Related Information	Removed selected services within this coverage policy via telehealth added information: Concurrent Billing, Telehealth Billing, additional billing guidance

Date	Section or Subsection Amended	Change
		added new requirements for telehealth billing for CPT code 97155 per Session Law2026-1 House Bill 696. legislation added caregivers telephonic billable requirements Added C.1 Prior Approval and Authorization updated language to clarify specific codes do not require a service order or Treatment Plan for Prior Approval. Added New Requirement to include “Service Hour Ratios for LQASP-to Paraprofessionals-Delivered Services” per Session Law2026-1 House Bill 696. Added incidental supervision is not billable
08/01/2026	Attachment B: Applied Behavior Analysis Service Definition	New attachment, Applied Behavior Analysis Service Definition

Attachment A: Claims-Related Information

Provider(s) shall comply with the *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

A. Claim Type

Professional (CMS-1500/837P transaction) billed through the health plan or other dedicated vendor.

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

Note: Providers using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–5) manual shall submit claims using the ICD-10 diagnosis code that corresponds to the chosen DC:0-5 diagnosis.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Refer to **Attachment B Applied Behavior Analysis Service Definition, Provider Requirements and Roles** for eligible ABA providers who can deliver each CPT code below.

CPT Code(s)		Concurrent Billing Allowed	Telehealth Billable Services (with GT modifier)	Telephonic Billable Services (with KX modifier)
97151	1 unit = each 15 - minute increment	No	Yes	No
97152	1 unit = each 15 - minute increment	No	No	No
97153	1 unit = each 15 - minute increment	Yes	No	No

91754	1 unit = each 15 - minute increment	Yes	No	No
97155	1 unit = each 15 - minute increment	Yes	Yes	No
97156	1 unit = each 15 - minute increment	No	Yes	Yes
97157	1 unit = each 15 - minute increment	No	Yes	Yes

Concurrent Billing Allowed:

97153- Yes; with 97155, when the paraprofessional is delivering 97153 with observation from an eligible provider (refer to **Attachment B** Applied Behavior Analysis Service Definition, Provider Requirements and Roles).

97154- Yes; with 97155, when the paraprofessional is delivering 97154 with observation from an eligible provider (refer to **Attachment B** Applied Behavior Analysis Service Definition, Provider Requirements and Roles).

97155- Yes, with 97153 or 97154. A single rendering provider may not bill 97153 or 97154 and 97155 simultaneously.

Telehealth Billable Services with GT Modifier:

97151- provider(s) shall provide clinical justification in the beneficiary's Treatment Plan if delivering this service via telehealth.

97155- telehealth may be used up to a maximum of 50% of total 97155 billing per beneficiary per 180-calendar day period. Provider(s) shall provide clinical justification in the beneficiary's Treatment Plan if additional telehealth units are required. Refer to **5.3.3 Treatment Plan** for Treatment Plan requirements.

Telephonic Billable Services (with KX modifier):

97156- If the criteria in **subsections 3.1.2 and 3.2.5** are met, the following services shall be offered via telephonic modality.

97157- If the criteria in **subsections 3.1.2 and 3.2.5** are met, the following services shall be offered via telephonic modality.

A provider shall document that Caregivers meet one for the following conditions when delivering one of the above Telephonic Billable Services (97156, 97157 with KX modifier) via telephone.

- a. The Caregiver's physical or behavioral health status prevents them from participating in in-person or telehealth services; or
- b. Access issues (transportation, telehealth technology) prevent the Caregiver from participating in in-person or telehealth services.

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

Note: Please refer to Clinical Coverage Policy 1-H: Telehealth, Virtual Patient Communications, and Remote Patient Monitoring for utilization and billing guidance on virtual patient communication codes (online digital E&M, telephonic E&M, and interprofessional consultation) and remote patient monitoring codes (self-measured blood pressure and remote physiologic monitoring) billable by eligible psychiatric prescribers but which are not contained in Clinical Coverage Policy 8F.

C.1 Prior Approval and Authorization:

97151 and 97152- do not require a service order or Treatment Plan for Prior Approval. A service order must be in place prior to the date services are provided under CPT codes 97153, 97154, 97155, 97156, or 97157.

Additional Billing Guidance for CPT Code 97155 (Adaptive Behavior Treatment and Modification of Protocol):

CPT code 97155 may be billed when the observing provider provides direct treatment to the beneficiary to observe changes in behavior or troubleshoot treatment protocols; or the observing provider joins the beneficiary and a paraprofessional during a treatment session to direct the paraprofessional in implementing a new or modified treatment protocol. In the second case, 97153 should be reported concurrently (see **Concurrent Billing Allowed** above).

Service Hour Ratios for LQASP- to Paraprofessional-Delivered Services

For beneficiaries who receive more than 200 hours of RB-BHT services from paraprofessionals in a 180 -calendar day period, the ratio of LQASP-delivered services to paraprofessional-delivered services should be no less than one hour for every 10 hours of service (10 percent) and no more than two hours for every 10 hours of services (20 percent). This ratio must be documented in the Treatment Plan. Any Treatment Plan requesting a ratio outside the 10 percent - 20 percent range is required to include a written clinical justification. The ratio is measured over 180-calendar day authorization period.

This service hours ratio shall be calculated as follows:

1. The numerator is the number of hours billed by the provider for services provided by LQASPs for all service dates occurring in the applicable 180-calendar day period for the Medicaid beneficiary.
2. The denominator is the number of hours billed by the provider for services provided by paraprofessionals for all service dates occurring in the applicable 180-calendar day period for that same Medicaid beneficiary.

Activities that are **not** billable include incidental supervision to ensure the paraprofessional:

- a. Practices in a competent, professional, and ethical manner in accordance with the standards of the profession, licensure, certification standards;
- 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.

D. Modifiers

Non-Telehealth Claims: Provider(s) shall follow applicable modifier guidelines.

Telehealth Claims: Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not appropriate for virtual patient communications or remote patient monitoring.

Telephonic Claims: Modifier KX must be appended to the CPT or HCPCS code to indicate that a service has been provided via telephonic, audio-only communication.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

F. Place of Service

RB-BHT services may include traditional approaches that are often provided in an office or clinic setting. RB-BHT services also include contextual approaches that are often provided in the community or in the home setting.

Treatment shall be provided in the setting most appropriate to the beneficiary's individual treatment goals. Place of service decisions shall be documented in the Treatment Plan and made on an individualized basis, in collaboration with the beneficiary's family. Settings may include clinic-based, home-based, school-based, or community-based settings or any combination throughout the full course of treatment, including up until discharge. For services that shall initially begin in a structured setting (clinic), the goal of the treatment should be to advance towards treatment in the beneficiary's natural setting (non-clinical settings).

Delivering services to a beneficiary's natural environment must be done in a respectful manner (team members shall not appear at the beneficiary's place of work without receiving permission to do so beforehand).

Telehealth and telephonic claims should be filed with the provider's usual place of service code(s).

G. Co-payments

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at <https://medicaid.ncdhhs.gov/meetings-notice/medicaid-state-plan-public-notice>

A qualified provider who renders services to a Medicaid beneficiary shall bill all other third-party payers, including Medicare, before submitting a claim for Medicaid reimbursement.

H. Reimbursement

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>

Attachment B: Applied Behavior Analysis Service Definition

A. Medicaid Billable Service

The requirements in this Attachment apply only to ABA services. Providers delivering ABA must comply with all requirements addressed in this policy in addition to those described in this Attachment.

B. Service Definition and Required Components

ABA is an evidence-based, validated, RB-BHT modality that focuses on analyzing, designing, implementing, and evaluating social and other environmental modifications to produce meaningful changes in a beneficiary's behavior.

The core characteristics of ABA are:

- a. Objective evaluation and analysis of the beneficiary's condition by examining how environmental factors influence behavior, as demonstrated through appropriate measurement;
- b. Consideration of the context surrounding the behavior and the significance of that behavior to the beneficiary, their Caregivers, and the broader community;
- c. Promotion of the beneficiary's dignity;
- d. Application of the principles and methods of behavior analysis to enhance the beneficiary's health, skills, independence, quality of life, and autonomy; and
- e. Ongoing, consistent, and objective analysis of data to guide clinical decision making.

C. Provider Requirements and Roles

ABA services must be delivered by one of the following provider types:

- a. Behavior technician as defined under N.C. Gen. Stat. §90-732(2).
- b. To be eligible to provide Medicaid services, behavior technicians must be certified by either the Behavior Analyst Certification Board as a Registered Behavior Technician, or by the Qualified Applied Behavior Analysis Credentialing Board as an Applied Behavior Analysis Technician. Behavior technicians must obtain and provide evidence of the required certification to the provider agency within 120 calendar days from the individual's date of hire; or the date on which the employing provider of RB-BHT services first enrolls as a Medicaid provider, whichever is later. Behavior technicians may render RB-BHT services during the 120 calendar days under all required supervision as described in this policy and as relevant to North Carolina statute. If the behavior technician does not obtain the required certification within 120 calendar days from their date of hire, they must cease rendering services until they obtain or provide evidence of certification to the provider agency.
- c. Licensed assistant behavior analyst (LaBA) as defined under N.C. Gen. Stat. § 90732(6).
- d. Licensed behavior analyst (LBA) as defined under N.C. Gen. Stat. §90-732(7).
- e. Physician (MD or DO) for whom ABA services are within the scope of practice permitted in North Carolina and within their experience and competence.
- f. Licensed Psychologist for whom ABA services are within the scope of practice permitted in North Carolina and within their experience and competence as defined by Article 18G of the Psychology Practice Act.

- g. Licensed Psychological Associate, with supervision if required as defined by Article 18G of the North Carolina Psychology Practice Act, and for whom ABA services are within the scope of practice permitted in North Carolina and within their experience and competence as defined by Article 18G of the Psychology Practice Act.
- h. Non-licensed behavior analysts or assistant behavior analysts who are supervised by a Licensed Psychologist (or Licensed Psychologist Associate with supervision, if required as defined by Article 18G of the North Carolina Psychology Practice Act).

D. Provider types eligible to develop, modify, and supervise implementation of an ABA Treatment Plan

- a. LBA as defined under N.C. Gen. Stat. §90-732(7); or
- b. Physician (MD or DO) for whom ABA services are within the scope of practice permitted in North Carolina and within their experience and competence; or
- c. Licensed Psychologist or Licensed Psychological Associate (with appropriate supervision, as defined by Article 18G of the Psychology Practice Act) for whom ABA services are within the scope of practice permitted in North Carolina and within their experience and competence as defined by Article 18G of the Psychology Practice Act.

E. ABA Rendering Providers

97151	• Physician • Licensed Psychologist or Licensed Psychological Psychologist Associate (with required supervision as defined by Article 18G of the North Carolina Psychology Practice Act) • LBA
97152 97153 97154	• Behavior technician under the direction of a physician, Licensed Psychologist or Licensed Psychological Associate (with required supervision as defined by Article 18G of the North Carolina Psychology Practice Act); • LBA; • non-licensed behavior analyst, under required supervision; • Behavior technician under the direction of an LaBA non-licensed assistant behavior analyst, both under required supervision; • Physician, Licensed Psychologist, or Licensed Psychological Psychologist Associate (with required supervision as defined by Article 18G of the North Carolina Psychology Practice Act), or LBA, or non-licensed behavior analyst, under required supervision.
97155	• Physician • Licensed Psychologist or Licensed Psychological Psychologist Associate (with required supervision as defined by Article 18G of the North Carolina Psychology Practice Act) • LBA; or non-licensed behavior analyst, under required supervision • LaBA; or non-licensed assistant behavior analyst, under required supervision.

97156 97157	• Physician • Licensed Psychologist or Licensed Psychologist Associate (with required supervision as defined by Article 18G of the North Carolina Psychology Practice Act • LBA
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