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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.

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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

2A-3, Out-of-State Services

1.0 Description of the Procedure, Product, or Service

Research-Based Behavioral Health Treatment (RB-BHT) is a researched-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 and adaptive functioning of the beneficiary.

Research-Based Behavioral Health Treatment (RB-BHT) services are researched-based behavioral intervention services, which have demonstrated clinical efficacy, that prevent or minimize the disabilities and behavioral challenges associated with Autism Spectrum Disorder (ASD) and promote, to the extent practicable, the adaptive functioning of a beneficiary. prevents or minimizes the adverse effects of ASD; and promotes, to the maximum extent possible, the functioning of a beneficiary.

RB-BHT services include the following: but are not limited to, the following categories of Research-Based interventions

- a. Behavioral, Adaptive or Functional assessment and development of an individualized Treatment Plan;
- b. Delivery of RB-BHT services, which includes:
 1. Adapting the environments 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 (individuals who do not have ASD) to teach and interact with children with ASD (e.g., peer mediated instruction, structured play groups);
 5. Applying technological tools to change behaviors and teach skills (e.g., video modeling, tablet-based learning software); and
 6. Training of parents, guardians, and caregivers on interventions consistent with the RB-BHT.

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Observation for modification of Intervention and Technician Direction shall be provided when: Directing: Provider's observation and direction of the Paraprofessional (Board Certified Assistant Behavior Analyst [BCaBA] or Technician), which is allowed only when:

1. the Performing observing provider is in the same room or via telehealth in accordance with subsection 3.1.1 as the provider delivering in-person treatment to the beneficiary. or using Telehealth in accordance with section 3.1.1, as both the individual and the paraprofessional (BCaBA or technician);
2. the observation is for the benefit of the individual. The Performing 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 individual. 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 an individual. Refer to sub section 6.1 Provider Roles and Attachment B, 10 percent of all approved services should be observed by the provider. An excess of percent of observation must be clinically justified; and

d. In addition to the categories of interventions listed above, covered RB BHT services are any other intervention supported by credible scientific or clinical evidence, as appropriate for the treatment of Autism Spectrum Disorder.

An intervention is considered to have credible scientific or clinical evidence if it meets the specific criteria listed below:

1. Randomized or quasi-experimental design studies. Two high quality experimental or quasi-experimental group design studies conducted by at least two different researchers or research groups;
2. Single subject design studies. 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; or
3. Combination of evidence. 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
4. Interventions programs that have a strong evidence base for American Indian youth and Promising Practice interventions that are culturally grounded and community driven programs that are supported by tribal communities.

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1.1 Definitions

Preventative

Preventative means to **To** anticipate the development of a disease or condition and preclude its occurrence.

Diagnostic

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

Diagnosis

Diagnosis is defined as the **Is the** identification of the nature of an illness or other problem by examination of the symptoms.

Therapeutic

Therapeutic means to **To** treat and cure disease or disorder; it may also preserve health.

Rehabilitative

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

Habilitative services

Habilitative services are defined as **Are** health care services that help a person learn, keep or improve skills and functioning for daily living. **Examples- This** includes therapy for a child who **isn't is not** walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and outpatient settings.

Caregivers

Caregiver in this policy refers to the following individual(s): Parent(s) (as defined in 42 C.F.R. § 435.603(b)); Guardian(s) (as defined in G.S. 35A-1202); 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

~~Professional~~ Provisional Diagnosis is defined as **Is a** diagnosis for **an** individual under three years of age that is **made** determined by a licensed professional as provisional or “rule-out” based on significant concern for ASD (*For Example* **physician screening results, early intervention documentation of concern, or observation of symptoms in combination with caregiver concern** **physician screening results, parent report, early intervention documentation of concern, or observation of symptoms**) when a comprehensive evaluation has not yet been completed. **Refer to subsection 3.2.1 Specific Criteria Covered by Medicaid for diagnosing provider criteria.** Provisional diagnosis may be made by Licensed Psychologist, physician, or licensed clinicians with a master’s degree for whom this service is within their scope of practice (*For Example* Licensed Psychologist Associate, Licensed Clinical Social Worker). **individuals shall have an ASD Diagnosis within six months of the provisional diagnosis.**

Applied Behavior Analysis (ABA)

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

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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, an individual may become retroactively eligible for Medicaid while receiving covered services.

Retroactively eligible beneficiary are entitled to receive Medicaid covered services and to be reimbursed by the provider for all money paid during the retroactive period with the exception of 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).

Medicaid beneficiary, under 21 years of age, who meet the criteria in **Section 3.0** of this policy are 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 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.

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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;

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- 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 within-in this clinical coverage policy that are may be provided via the telephonic, audio-only communication method. Telephonic services may shall be transmitted between a patient and provider in a manner that is consistent with the CPT code and definition for those services.

Select RB-BHT services shall be provided telephonically when the following criteria are met:

~~This service delivery method is reserved for circumstances when:~~

- a. The provider must ensure that services can be safely and effectively delivered using telephonic, audio-only communication;

Providers shall consider the caregiver's abilities to participate in services provided using telephonic, audio-only communication;

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

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 § 90-731);

Providers must obtain and document verbal or written consent in extenuating circumstances when consent is unable to be obtained, this should be documented;

Providers must verify the caregiver's identity using two points of identification before initiating a telephonic, audio-only encounter. Providers shall verify caregivers identity through verification of the beneficiaries name and one of the following:

1. Beneficiary Medicaid Identification number, or
2. Beneficiary address.

Providers shall ensure that the beneficiary and caregivers' Protected Health Information (PHI) are protected.

One of the following:

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- i. The caregiver's physical or behavioral health status prevents them from participating in in-person or telehealth services; or
- ii. Access issues (e.g., transportation, telehealth technology) prevent the caregiver from participating in in-person or telehealth services.

Refer to **Subsection 3.2.5** for Telephonic Specific Criteria; Refer to **Subsections 5.1 and 5.2** for Prior Approval requirements; and **Subsection 7.1** for Compliance requirements.

3.1.3 Covered Modalities and Interventions

Covered RB-BHT modalities and interventions-services include but are not limited to the following examples, which have been supported by credible scientific or clinical evidence as appropriate for Autism Spectrum Disorder: are any intervention supported by credible scientific or clinical evidence, as appropriate for the treatment of Autism Spectrum Disorder including for example:

- a. Applied behavior analysis
- 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)

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 must ensure the intervention is supported by credible scientific or clinical evidence, demonstrated by meeting one or more of the criteria listed below:

- a. Randomized or quasi-experimental design studies. Two high quality experimental or quasi-experimental group design studies conducted by at least two different researchers or research groups; or
- b. Single-subject design studies. 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; or
- c. Combination of evidence. 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 programs that have strong evidence base for American Indian youth and Promising Practice interventions that are culturally grounded and community driven programs that are supported by tribal communities.

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3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

Medicaid shall cover RB-BHT services for beneficiary under 21 years of age diagnosed with ASD utilizing a scientifically validated diagnostic tool, or tools, for diagnosis of ASD, including individuals diagnosed under Section 8A of the State Plan. For any individual under three years of age, at the time of initiating services, a provisional diagnosis of ASD is accepted. Individuals should have an ASD diagnosis within six months of the provisional diagnosis.

Medicaid shall cover RB-BHT services for a beneficiary 21 years of age and older diagnosed with ASD. Utilizing a scientifically validated diagnostic tool, or tools for diagnosis of ASD refer to **subsection 3.2.3.**

For a beneficiary, 21 years of age and older, the intervention provided must be supported by credible scientific or clinical evidence, as age range. RB-BHT services shall not be initiated based solely on screening tools, educational determinations, or informal clinical impressions. For any individual under three years of age, at the time of initiating services, a provisional diagnosis of ASD is accepted.

A provisional diagnosis of ASD is a diagnosis made by a licensed professional as a rule-out based on significant concern for ASD (For Example physician screening results, parent report, early intervention documentation of concern, or observation of symptoms) when a comprehensive evaluation has not yet been completed. Provisional diagnosis may be made by licensed psychologist, physician, or clinicians with a master's degree for whom this service is within their scope of practice (For Example licensed Psychological Associate, Licensed Clinical Social Worker)

RB-BHT teams shall document a written assessment that reflects the following medical necessity criteria: required:

- a. the beneficiary has a current diagnosis recognized by the American Psychiatric Association Diagnostic and the current edition of the Statistical Manual (DSM) (or its subsequent edition) in concordance with an Autism Spectrum Disorder diagnosis reflecting the need for treatment;
- b. the covered treatment must be medically necessary for preventing and minimizing the disabilities associated with of ASD;

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- ~~e. for beneficiary under three years of age at the time services are initiated, a provisional diagnosis of ASD is accepted;~~
- ~~d. the Research Based Behavioral Health Treatment being requested has clinical efficacy in treating ASD;~~
- ~~e. based on the current or Psychological or adaptive or other relevant assessments that informs the plan, this service is indicated;~~
- ~~f. this service prevents or minimizes the disability and behavioral challenges associated with ASD;~~
- ~~g. this service promotes the adaptive functioning of the beneficiary;~~
- ~~h. there is evidence that this intervention is equally or more effective than an alternative intervention based on North Carolina community practice standards (Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine); and~~
- ~~i. there are no indications that available alternative interventions would be equally or more effective based on North Carolina community practice standards and within the Local Management Entity-Managed Care Organization (LME MCO) (or subsequent System) service array.~~

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. physician screening results, parent report, early intervention documentation of concern, or observation of symptoms) when a comprehensive evaluation has not yet been completed.~~

~~Individuals must have an ASD diagnosis within six months of the provisional diagnosis. Provisional diagnosis may be made by:~~

- ~~a. Licensed Psychologist;~~
- ~~b. a Licensed Psychologist Associate (with required supervision as defined by Article 18G of the North Carolina Psychology Practice Act);~~
- ~~c. a physician [Medical Doctor (MD) or,~~
- ~~d. Licensed Doctor of Osteopathic Medicine (DO)];~~
- ~~e. or clinicians with 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.~~

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3.2.4 Non-Provisional Diagnosis

A non-provisional ASD diagnosis must be made using one of the following scientifically validated tools:

- a. Brief Observation of Symptoms of Autism (BOSA),
- b. Tele-ASD-Peds (TAP), or
- c. Autism Diagnostic Observation Schedule, Second Edition (ADOS-2).

Non-provisional diagnoses must be made by a Licensed Psychologist (when 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 may be used by an eligible diagnosing provider to inform a non-provisional diagnosis.

3.2.5 Medical Necessity Criteria

Medicaid shall cover RB-BHT when Medically necessary for beneficiary with Autism Spectrum Disorder (ASD). RB-BHT providers shall document a written assessment that reflects the following medical necessity criteria:

- a. the beneficiary has a current Autism Spectrum Disorder diagnosis 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 beneficiary under three years of age at the time services are initiated, a provisional diagnosis of ASD 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. 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;
- e. this service promotes the adaptive functioning of the beneficiary;
- f. this service promotes the adaptive functioning of the beneficiary;
- g. there is evidence that this intervention is equally or more effective than an alternative intervention based on North Carolina community practice standards (Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine); and
- h. there are no indications that available alternative interventions would be equally or more effective based on North Carolina community practice standards and within the health plan (or subsequent System) service array.

~~RB-BHT is covered when medically necessary for a beneficiary with ASD. RB-BHT teams providers shall document a written assessment that reflects the following required medical necessity criteria: required:~~

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- a. the beneficiary has a current ASD diagnosis recognized by the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders the current edition of the Statistical Manual (DSM) (or its subsequent edition) in concordance with an Autism Spectrum Disorder diagnosis reflecting the need for treatment;
- b. for beneficiary under three years of age at the time services are initiated, a provisional diagnosis of ASD is accepted the covered treatment must be medically necessary for preventing and minimizing the disabilities associated with of ASD;
- c. for beneficiary under three years of age at the time services are initiated, a provisional diagnosis of ASD is accepted;
- d. the Research-Based Behavioral Health T treatment type and treatment intensity (number of hours) being requested are medically necessary, not in excess of the beneficiary's needs, and has clinical efficacy scientifically demonstrated to address adaptive functioning and prevent or minimize ASD-related disabilities and behavioral challenges; nd is in treating ASD;
- e. based on the current or Psychological or adaptive or other relevant assessments that informs the plan, this service is indicated; the service is indicated based on current psychological and other relevant assessments that inform the Treatment Plan;
- f. this service prevents or minimizes the disability and behavioral challenges associated with ASD;
- g. this service promotes the adaptive functioning of the beneficiary;
- h. there is evidence that this intervention is equally or more effective than an alternative intervention based on North Carolina community practice standards (Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine); and
- i. there are no indications that available alternative interventions would be equally or more effective based on North Carolina community practice standards and within the NC benefit array. Health plan Local Management Entity Managed Care Organization (LME-MCO) (or subsequent System) service array.

3.2.6 Initial Process

According to 42 CFR 440.130(c), RB-BHT services are covered as medically necessary services based upon the recommendation and referral of a licensed physician or a licensed doctorate-level psychologist for a beneficiary who has been diagnosed with ASD.

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3.2.7 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.

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 5.3.4** Treatment Plan for Treatment Plan requirements).

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

A Licensed Medical Doctor (MD), Licensed Doctor of Osteopathic Medicine (OD), or Licensed Psychologist according to 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. The service order must be based on a Behavioral, Adaptive, or Functional Assessment of the beneficiary's needs.

Service orders are valid for one year. Medical necessity must be revised, and services must be ordered at least 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

3.2.8 Continued Stay Criteria

Medicaid shall cover a continued stay if:

- a. the desired outcome or level of functioning is not restored, improved, or sustained over the timeframe outlined in the beneficiary's Treatment Plan; 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;

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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;
5. is effectively functioning with this service and discharge would otherwise be indicated, however titration of this service is expected. 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 clinically sound expectation that the core and associated deficits of ASD persist and that ongoing treatment interventions are needed to sustain functional gains.

3.2.9 Transition or Discharge Criteria

The RB-BHT provider must implement a treatment program transition or discharge plan when a beneficiary shall meet at least ONE of the following criteria: to be considered for transition or discharge from a treatment program:

- ~~a. the beneficiary ages out of the service;~~
- a. the family, caregiver, 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 appropriate 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 level of support would adequately address current goals (see subsection 5.3.4 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;

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- 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 legally responsible person, chooses to withdraw from services and documented attempts by the program to re-engage the beneficiary with the service have not been successful;
- 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 a clinically sound expectation that ongoing treatment interventions are needed to sustain functional gains; or
- j. the beneficiary has not demonstrated significant improvement following reassessment and **reasonable** ~~several~~ adjustments to the Treatment Plan, personnel or modality over at least six months 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.

Telephonic-Specific Criteria

- ~~a. Providers shall ensure that services can be safely and effectively delivered using telephonic, audio only communication;~~
- ~~b. Providers shall consider the caregiver's abilities to participate in services provided using telephonic, audio only communication;~~
- ~~c. 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 Licensing Board rules;~~
- ~~d. Providers shall obtain and document verbal or written consent. In extenuating circumstances when consent is unable to be obtained, this should be documented;~~
- ~~e. Providers shall verify the caregiver's identity using two points of identification before initiating a telephonic, audio only encounter; and~~
- ~~f. Providers shall ensure that the beneficiary and caregivers' privacy and confidentiality is protected.~~

~~Transition and discharge planning from a treatment program must document a written plan that specifies details for monitoring and~~

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~~follow up as appropriate for the beneficiary and family or caregiver.~~

~~The Treatment Plan is not to be used to provide respite, day care, or educational services and is not to be used to reimburse a parent for participating in a treatment program. The treatment or discharge plan must be available to a health plan upon request. A unit of service is defined according to the Current Procedural Terminology (CPT) approved code set unless otherwise specified.~~

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. **Non-therapy or unstructured** time spent doing, attending or participating in recreational activities (e.g., naps, lunch, breaks, transportation) unless **activities are tied to specifically tied to an authorized planned social skill training or other therapeutic interventions related to a** Treatment Plan goal;
- b. services **provided to** teaching academic subjects or as a substitute for educational personnel, including a **the following 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, respite, or habilitative services** **respite care;**
- e. covered services that have not been rendered;
- f. services not identified on the beneficiary's authorized Treatment Plan;
- g. services provided without prior authorization by the PHP;
- h. 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

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beneficiary's issues and not ~~included in~~ ~~listed on~~ the eligible beneficiary's Treatment Plan;

- i. ~~Treatments that are not based in scientific evidence and unproven treatment services that are not based in credible scientific or clinical evidence; or~~
- j. ~~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;~~
- k. ~~staff-only meetings and training;~~
~~administrative tasks and documentation; or~~
~~any service not covered in Section 3.0 of this policy.~~

4.2.2 Medicaid Additional Criteria Not Covered

~~None Apply~~

~~Medicaid shall not cover services when provided by Out-of-State (OOS) rendering providers. OOS providers are those located more than 40 miles outside of the borders of North Carolina.~~

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 (see Section 5.3.4 for Treatment Plan requirements) and the assessment used to inform the Treatment Plan (refer to Section 5.3.2 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 individual being treated as developed by a Licensed Qualified Autism Service Provider (LQASP). The Treatment Plan shall be reviewed at least ~~no less than~~ once every six months by an LQASP ~~(or other eligible provider as specified in Attachment B,~~ and modified whenever appropriate. ~~Extension of service authorization must be received to continue coverage of the service.~~ Services provided without prior authorization are not considered for payment or reimbursement except in the case of retroactive Medicaid eligibility.

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, ~~except in the case of a Treatment Plan involving more than 16 hours of services per week, which must be reviewed, modified, and submitted for reauthorization at least monthly according to Section 3C.18,(a) Sessions Law 2026-1~~ Refer to **Subsection 2.1.2.**

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Reauthorization

Extension of service authorization must be received to continue coverage of the service. An authorized Treatment Plan shall be reviewed and modified and submitted for reauthorization at least once every 180 calendar days. Medicaid covers up to 180 calendar days for the reauthorization, 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 Medicaid beneficiary who are three years of age or older, Research-Based Behavioral Health Treatment services require Prior Approval by the PIHP health plan. The PIHP health plan approves the Treatment Plan of care and may approve or reduce or deny services.~~

~~For Medicaid beneficiary under three years of age, Research-Based Behavioral Health Treatment services require Prior Approval by the PIHP health plan or the State designated vendor.~~

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

All Each RBBHT 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 Section 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.

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All providers must submit the following assessments and supporting information for each beneficiary:

- a. At least one of the following adaptive behavior assessments completed within the last 3 years for beneficiary within the developmental period: Vineland Adaptive Behavior Scales, Third Edition (VABS-3), Adaptive Behavior Assessment System, Third Edition (ABAS-3), or Developmental Profile 4 (DP-4); or subsequent editions of these tools;
- b. A developmental or cognitive assessment (if not previously conducted within the past year for a child younger than 8 years old, or within the past 3 years for a child 8 years old or older [e.g., via school evaluation, Children's Developmental Services Agency]). Examples of commonly administered developmental/cognitive assessments include: Developmental Profile, Developmental Assessment of Young Children (DAYC), Differential Ability Scales (DAS), Mullen Scales of Early Learning, Bayley Scales of Infant Development, Wechsler series, Stanford-Binet, or Leiter;
- c. Developmental/medical history (as available), including member's developmental and chronological age, biopsychosocial history, presence of any co-occurring medical, psychiatric, or genetic conditions, history of services received, and response to current/prior treatments; and
- d. Available and relevant supplementary information including interviews, chart reviews, and observation notes.
- e. The following intervention planning and progress monitoring materials:
 1. At least one instrument, depending on the individual's scope of treatment:
 - A. For comprehensive early intervention (skills assessment to guide the development of objectives, treatment planning, and measurement of progress): Either the Verbal Behavior Milestones Assessment and Placement Program, Assessment of Basic Language and Learning Skills- Revised, or ESDM Curriculum Checklist; or
 - B. For targeted interventions to address specific behavior challenges: Functional behavior assessment or, at provider option, a functional behavioral analysis. Functional behavioral analyses is needed only in cases of highly challenging (i.e., dangerous, aggressive) behaviors.
 - C. Measure of parent/family functioning: Documentation of family resources, stressors, strengths, and goals within treatment plan. Providers have the option of submitting the PSI-4.

Providers may substitute an alternative tool in the event that required instruments are not clinically indicated for the beneficiary, and submit clinical justification.

Results from all relevant and applicable assessments must be used to inform development of a Treatment Plan conducted for the beneficiary, including (as applicable):

- a) Norm and/or criterion-referenced scientifically validated assessment instruments;

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- ~~b) Functional assessments (e.g. caregiver reports, direct observations);~~
- ~~c) Skill-based assessments;~~
- ~~d) Risk assessments; and~~
- ~~e) Assessments or information from assessments conducted by the beneficiary's school or other providers.~~

5.3.2 Treatment Plan Development

All RB-BHT Services must be provided and supervised under an approved Treatment Plan developed by an LQASP or other eligible provider as specified in **Attachment B, Applied Behavior Analysis Service Definition, Provider Requirements and Roles**. Coverage is limited to medically necessary services.

An LQASP is a person, entity, or group who meets ONE of the following credentials:

- a. licensed as a physician (MD or DO) or developmental and developmental/behavioral pediatrician or psychologist;
- b. Licensed Psychologist Associate (with required supervision as defined by Article 18G of the North Carolina Psychology Practice Act);
- c. occupational therapist;
- d. speech-language pathologist;
- e. clinical social worker;
- f. **License Clinical Mental Health Counselor** or professional counselor;
- g. licensed marriage or family therapist; or
- h. other licensee 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.

5.3.3 Treatment Plan

The Treatment Plan must be signed and dated by the LQASP (or other eligible provider as specified in **Attachment B Applied Behavior Analysis Service Definition, Provider Requirements and Roles**) responsible for the Treatment Plan and the beneficiary's legally responsible person [as defined by Chapter 122C, Article 1 (20)] prior to delivery of services.

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

- a. RB-BHT Services require a Treatment Plan. A Treatment Plan must be person-centered, developmentally appropriate, and individualized.
- b. Treatment Plans must be individualized to the beneficiary's strengths, functional impairments, adaptive skill levels, and developmental profile.
- c. Treatment Plans shall not include default recommended service hours. All services, including service intensity, shall be based upon an individualized clinical justification.

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- d. Providers must 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.

~~RB-BHT Services require a Treatment Plan. The Treatment Plan must contain ALL of the following elements:~~

- ~~a. be person-centered and developmentally appropriate with individualized goals;~~
- ~~b. describe the beneficiary's behavioral health or developmental skills and challenges that are to be treated;~~
- ~~e. delineate an intervention plan that documents:~~
- ~~1. the service type; number of hours of direct service and supervision;~~
 - ~~2. location of the service;~~
 - ~~3. parent/guardian/caregiver participation needs to: achieve the long-term, intermediate, and short-term goals and objectives that are specific, behaviorally defined, measurable, and based upon clinical observation;~~
 - ~~4. the frequency at which the beneficiary's progress is evaluated and reported; and~~
 - ~~5. identifies the individual providers responsible for delivering the services. Individual provider list can be modified with the beneficiary's and legal guardian's consent;~~
- ~~d. provide intervention plans that utilize research-based practices, with demonstrated clinical efficacy in treating ASD and that are specific to the individual's needs and developmental level;~~
- ~~e. include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives and goals identified in the intervention plan; and~~
- ~~f. update goals and objectives when the treatment goals and objectives are achieved or no longer appropriate;~~
- g. Must be signed and dated by Plan Developer and Legally Responsible Person prior to delivery of services.

5.3.3.1 Beneficiary Background Information and Case Conceptualization

- a. The Treatment plan must include the following elements:
- b. The beneficiary's developmental and chronological age
- c. Beneficiary's diagnosis (autism spectrum disorder and or any co-occurring medical conditions, including behavioral health)
- d. Referring provider and referring provider's agency; and referral reason (i.e., presenting concerns of the patient and family)

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

5.3.3.2 Assessment of Data and Information

Treatment plans shall include assessments and information specified in specified in Section 5.3.1.

5.3.4.3 Treatment Interventions, Scope, and Goals

- a. Treatment Plan shall include Treatment interventions specified in Section 3.1.3 (i.e., the research-based models or modalities) that will be used.
Scope of treatment (focused or comprehensive, according to the guidelines below):
 - 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 (e.g., cognitive, social, behavioral, adaptive).
 - 3. Defined, measurable treatment goals with current baselines and measurement methods for each goal, including starting points, mastery criterion and target dates, intervals for frequency of measurement:
 - 4. Goals must be specific, behaviorally defined, measurable, and based upon clinical observation.
 - 5. Goals must be updated when the treatment goals and objectives are achieved or no longer appropriate.

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6. Goals must identify the family/primary caregivers' priorities across home, school, and community settings and include caregiver training objectives to promote generalization and maintenance of skills (see below for requirements specific to caregiver training).
- b. Outcome measurement assessment criteria that will be used to measure achievement of treatment objectives and goals;
- c. Frequency at which the beneficiary's progress is evaluated and reported;
- d. Behavior reduction and acquisition procedures, including the conditions under which behavior is to be demonstrated, and mastery criteria achieved, to include the date of introduction, estimated a date of mastery, and a plan for generalization of skill(s); and
- e. Location of the service and treatment settings (home, school and community, outpatient/clinic, residential).

5.3.4.4 Treatment Intensity

The Treatment Plan shall 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.**
- b. Hours spent in educational settings and receiving Individualized Education Program services (refer to the **Outpatient Specialized Therapies Local Area Agencies Clinical Coverage Policy No.: 10C**) should not be included in the calculation of treatment hours
- c. The targeted ratio of observation with protocol modification (CPT code 97155) to adaptive behavior treatment (CPT code 97153 or 97154). Refer to **Attachment A**, for specific requirements.
- d. Clinical justification for service intensity that includes how service hours will be used.
- e. If applicable, clinical justification for providing treatment during school hours or in other non-natural settings (e.g., provider clinic).
- f. If applicable, clinical justification for not providing treatment in the beneficiary's natural setting(s).
- g. If applicable, clinical justification for use of telehealth or telephone.

5.3.4.5 Service Schedule

The Treatment Plan shall include a schedule of services to identify the following:

- a. Anticipated 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 service schedule must include the following, if received by the beneficiary:

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- c. RB-BHT services
- d. School-based services
- e. Respite services
- f. Outpatient specialized therapies (occupational therapy, physical therapy, speech and language therapy)
- g. Social skills training
- h. Other therapeutic or habilitative services related to skills acquisition or capacity building

5.3.4.6 Staffing

The Treatment plan shall include who will be responsible for delivery of services:

- a. Providers responsible for delivery of services. The provider list can be modified with the beneficiary's and legally responsible person's consent.

5.3.4.7 Titration Plan and Crisis Management

- a. The Treatment Plan shall include a plan for titration and crisis management.
- b. The titration plan contemplates 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 section 3.2.6 for more information on requirements related to transition or discharge that inform the titration plan)
- c. The titration plan must consider caregiver(s)' involvement required to modify/reduce service intensity.
- d. The titration plan must be in place at the start of treatment and modified as indicated based upon progress.
- e. The Crisis management plan (as applicable):
- f. The 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 debriefing process for plan review and updates
- g. The crisis management plan in the Treatment Plan should not be duplicative to existing care management crisis plans

5.3.4.8 Caregiver Involvement

The Treatment plan shall include the following elements to identify caregiver involvement:

- a. List of the beneficiary's caregiver(s), indicating which are primary (refer to Section 1.1.7. for the definition).
- b. The provider responsible for the Treatment Plan must share the Treatment Plan with, at a minimum, the beneficiary's legally

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responsible person [as defined by Chapter 122C. Article 1 (20)] and their primary caregiver(s) with all legally required consent.

- c. The provider must involve caregivers in assessment and treatment unless clinically contraindicated and documented. The Treatment Plan must reflect meaningful caregiver engagement. Providers must 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 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 and build functional skills in the beneficiary.

Each caregiver goal must include the following elements:

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

Caregiver involvement and training plan, to include the following requirements:

Training procedures, to include how the following aspects of caregiver training will be conducted, as applicable:

- a. Schedule of a minimum of six caregiver training sessions that must be completed per the six-month service authorization period.
- b. Providers must 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.
- c. Instructional content tailored to individual needs;
- d. Skill demonstration through guided examples;
- e. Hands-on practice for each skill with real-time support; and/or,
- f. Continued supports, including ongoing oversight and coaching, collaborative problem solving, promoting generalization and maintenance of skills, and assistance with applying strategies across new settings.

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- g. The ratio of caregiver involvement to direct service hours goals;
- h. A barrier analysis (i.e., indicating potential barriers to caregiver involvement and a plan to address these barriers);
- i. A plan for generalization of skills across settings; and
- j. As appropriate, a plan for engaging other individuals who provide care or support to the beneficiary on a regular basis (e.g., school staff, residential staff).

~~When developing a Treatment Plan, it is important, given the beneficiary's consent, to include people who are important in the beneficiary's life, such as family members, legally responsible person, professionals, friends and others identified by the beneficiary (for example, employers, teachers and faith leaders). These individuals can be essential to the planning process and help drive its success. Person-centered planning uses a blend of paid, unpaid, natural and public specialty resources uniquely tailored to the individual or family needs and desires. It is important for the person-centered planning process to explore and use all these resources.~~

5.3.5 Treatment Plan Reviews and Annual Rewriting Updates

~~All Treatment Plans must be reviewed and updated every 180 calendar days when reauthorization of services is required or more frequently, as needed. Treatment Plans involving more than 16 hours of services per week shall be reviewed, modified, and submitted for reauthorization at least monthly, per Section 3C.18.(a) Sessions Law 2026-1. updated as needed and must be rewritten at least annually.~~ At a minimum, the Treatment Plan must be reviewed by the responsible professional (refer to Attachment B, or 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 on the Treatment 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.

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5.4.4 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 ~~is~~ not required to countersign service notes written by a staff person who does not have LQASP or C-QP status.

5.4.4.1 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 contact as it relates to the goal(s) on the
- h. Treatment Plan;
- i. description of the intervention provided/services furnished: Documentation of the intervention must accurately reflect treatment for the duration of time indicated;
- j. (as applicable) whether a plan of care or treatment protocol modification was made;
- k. duration of service: Amount of time spent performing the intervention, including session time in/out;
- l. assessment of the effectiveness of the intervention and the beneficiary's progress towards the beneficiary's goal, including any data collected;
- m. (as applicable) Whether training was provided to one or more caregivers for a single or multiple beneficiary with or without the beneficiary present, including specific guidance provided to families to implement treatment (not general discussion);
- n. Caregiver(s) present;
- o. signature, date, and credentials or job title of the staff member who provided the service; and
- p. each service note page must be identified with the beneficiary's name, Medicaid identification number, and record number.

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Providers must 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.

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 Team;
- d. a plan for follow-up treatment, developed in conjunction with the beneficiary; and
- e. signatures of the beneficiary and the developer of the Treatment Plan (LAQSP and the C-QP); and
- f. a completed PIHP Health plan (or dedicated vendor) Consumer Admission and Discharge Form must be submitted to the LME-MCO health plan (or dedicated Vendor).

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

- ~~A. purpose of the contact as it relates to the goal(s) on the Treatment Plan;~~
- ~~B. description of the intervention provided. Documentation of the intervention must accurately reflect treatment for the duration of time indicated;~~
- ~~C. duration of service: Amount of time spent performing the intervention;~~
- ~~D. assessment of the effectiveness of the intervention and the beneficiary's progress towards the beneficiary's goal;~~

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.

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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 Licensed Qualified Autism Provider**:

- a. Physician, ~~developmental, or behavioral~~ pediatrician;
- b. Licensed Psychologist;
- c. Licensed Psychologist Associate **(with required supervision as defined by Article 18G of the North Carolina Psychology Practice Act)** ~~Assistant~~;
- d. Occupational Therapist;
- e. Speech and Language Pathologist
- f. Licensed Clinical Social Worker (LCSW);
- g. ~~Licensed Professional Counselor (LPC)~~ or Licensed Clinical Mental Health Counselor (LCMHC);
- h. Licensed Marriage and Family Therapist (LMFT); and
- i. **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. ~~The following types of staff are recognized as a Certified Qualified Professional:~~ A Certified Qualified Professional is a:

- a. ~~Board Certified Behavior Analyst (BCBA)~~
Other-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, C for requirements specific to behavior technicians providing ABA services.**

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.

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6.2 Provider Certifications

Competencies of ~~LQAPs Licensed Qualified Autism Professionals~~ and ~~C-QPs Certified Qualified Professionals~~ 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 ~~These~~ services are ~~regularly scheduled and~~ provided by a Licensed Qualified Autism Service Provider (LQASP) ~~provider~~, a Certified Qualified ~~Autism Provider~~ (C-QP), or a paraprofessional **Refer to Attachment B, these rendering providers shall provide RB-BHT services as follows:**

- a. Licensed Qualified Autism Service Provider **develops and modifies** the Treatment Plan and may also ~~supervises~~ observe or provide RB-BHT services.
- ~~b. A Certified Qualified Professional provides, supervises, or provides and supervises RB-BHT pursuant to a treatment plan developed by a LQASP. provides and supervises RB-BHT services pursuant to a Treatment Plan developed by a Licensed Qualified Autism Service provider.~~
- c. A paraprofessional provides RB-BHT services pursuant to a Treatment Plan developed by a ~~LQASP Licensed Qualified Autism Service provider~~ and be **supervised or observed to modify behavior interventions by a LQASP or C-QP.**

In addition to the ~~provider roles~~ **qualifications** 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;
- e. demonstrate that they meet these standards; ~~by being certified by the health plan~~ **Local Management Entities Managed Care Organizations (LME MCO)** (or applicable vendor);
- 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; and
- ~~e. providers must have competency in Cultural Humility~~

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.

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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 (in accordance with the authorities listed in **Subsection 7.3** of this policy). The LME/MCO health plan may also conduct compliance reviews and monitor provider organizations under the authority of DHB. Tribal providers are not subject to LME/MCO 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 finding 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

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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

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Date	Section or Subsection Amended	Change
		service codes indicating if the services are available 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	<p>Added: Non-Telehealth Claims</p> <p>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.</p> <p>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).</p>
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.
00/00/0000	1.0 Description of the Procedure, Product or Service	<p>Added Specific criteria for an intervention to be considered credible scientific or clinical evidence</p> <p>Added examples of covered RB-BHT services</p> <p>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":</p> <p>replaced “paraprofessional” (BCaBA or technician) with “provider”</p>
00/00/0000	1.1 Definitions	added definition for Caregivers

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Date	Section or Subsection Amended	Change
		Replaced “professional” with “provisional” in Provisional Diagnosis definition added definition for Applied Behavioral Analysis (ABA)
00/00/0000	2.1.2 Specific	removed "under 21 years of age"
00/00/0000	3.1.2 Telephonic Services	added services that may be provided telephonically and criteria
00/00/0000	3.2 Specific Criteria Covered	added: “providers shall document a written assessment that reflects medical necessity criteria” new subsection added: "Provisional Diagnosis" new subsection added: "Medicaid Necessity Criteria" removed sections: “Initial Process” and “Service Order”
00/00/0000	3.2.6 Transition or Discharge Criteria	added requirement for RB-BHT provider to implement treatment program transition or discharge plan added titration plan as part of Treatment Plan removed Telephonic Specific Criteria
00/00/0000	4.2 Specific Criteria Not Covered	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; ;Staff-only meetings and training; ; Administrative tasks and documentation; or any service not covered in Section 3.0 of this policy.”
00/00/0000	4.2.2 Medicaid Additional Criteria Not Covered	added language stating Medicaid shall not cover services when provided by out of state providers
00/00/0000	5.0 Requirements	added language stating prior approval is based on

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Date	Section or Subsection Amended	Change
	<u>for and Limitations of Coverage</u>	<u>review of beneficiary's Treatment Plan</u> <u>additional language added regarding extension of service authorization</u>
<u>00/00/0000</u>	<u>5.3 Additional Limitations or Requirements</u>	<u>Updated title to "Utilization Management and Additional Limitations"</u> <u>new section added "Service Order"</u> <u>added additional language for requirements to develop Treatment Plan</u> <u>added the following sections: Beneficiary Background Information and Case Conceptualization, Assessment of Data and Information, and Treatment Interventions, Scope, and Goals, Treatment Intensity, Service Schedule, Staffing, Titration Plan and Crisis Management</u> <u>Updated section title, "Treatment Plan Reviews and Annual Rewriting" to "Treatment Plan Reviews and Updates</u> <u>Additional language added to service note requirements</u>
<u>00/00/0000</u>	<u>6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service</u>	<u>additional language added to criteria for other certified or provisionally licensed professional</u>
<u>00/00/0000</u>	<u>Attachment A: Claims-Related Information</u>	<u>added information: Concurrent Billing, Telehealth Billing, additional billing guidance for CPT Code 97155</u> <u>new attachment. Applied Behavior Analysis Service Definition</u>

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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 **PIHP 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

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97152	1 unit = each 15 - minute increment	No	Yes No	No
97153	1 unit = each 15 - minute increment	Yes*	Yes No	No
91754	1 unit = each 15 - minute increment	Yes*	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, Telehealth, Telephonic billing allowed *

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 supervision 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 (applicable only to individual providers, not the provider organization).

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 20% of total 97155 billing per beneficiary. Provider(s) shall provide clinical justification in the beneficiary's Treatment Plan if additional telehealth units are required. Refer to **5.3.4 Treatment Plan** for Treatment Plan requirements.

Telephonic Billable Services (with KX modifier):

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

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

Providers shall document one of the following Services may be provided telephonic if caregivers meet one for the following:

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

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Prior Approval/Authorization:

97151 and 97152- do not require a service order or Treatment Plan for Prior Approval

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

Billable activities under CPT code 97155 include face-to-face monitoring observation of a paraprofessional's implementation of treatment protocols with the beneficiary present. These activities include providing real-time corrective feedback, demonstrating new or modified protocols for a technician or caregiver to observe, and actively troubleshooting treatment implementation.

Providers shall maintain a ratio of protocol modification (CPT 97155) to direct treatment (CPT 97153 and 97154) of no less than one hour for every 10 hours of service (10%) and no more than two hours for every 10 hours of service (20%). This ratio must be documented in the Treatment Plan. Any Treatment Plan requesting a ratio outside the 10% -20% range is required to include a written clinical justification.

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 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.

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 (e.g., online digital E&M, telephonic E&M, and interprofessional consultation) and remote patient monitoring codes (e.g., self-measured blood pressure and remote physiologic monitoring) billable by eligible psychiatric prescribers but which are not contained in Clinical Coverage Policy 8F.

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.

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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 relevant to the beneficiary's specific treatment goals. Services shall initially be provided in a structured setting (e.g. clinic) and then transition to more natural environments (e.g., home, school, or workplace) as progress is demonstrated. The goal of the treatment should be to advance towards treatment in the beneficiary's natural setting (i.e., non-clinical settings).

Delivering services to a beneficiary's natural environment must be done in a respectful manner (example, 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-notices/medicaid-state-plan-public-notices>

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/>

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Attachment B: Applied Behavior Analysis Service Definition

A. Medicaid Billable Service

The requirements in this Attachment apply only to Applied Behavior Analysis 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.
- 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)
 1. 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. 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.
- b. Licensed assistant behavior analyst (LaBA) as defined under N.C. Gen. Stat. § 90-732(6)

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- c. Licensed behavior analyst (LBA) as defined under N.C. Gen. Stat. §90-732(7)
- d. Physician (MD or DO) for whom ABA services are within the scope of practice permitted in North Carolina and within their experience and competence.
- e. 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.
- f. Licensed Psychologist 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.
- g. 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);
- 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; and
- c. Licensed Psychologist or Licensed Psychologist 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 Eligible to Bill Each CPT Code

97151	<ul style="list-style-type: none"> • Physician • Licensed Psychologist or Licensed Psychologist Associate (with required supervision as defined by Article 18G of the North Carolina Psychology Practice Act) • LBA
97152 97153 97154	<ul style="list-style-type: none"> • Behavior technician under the direction of a physician, Licensed Psychologist or Licensed Psychologist Associate (with required supervision as defined by Article 18G of the North Carolina Psychology Practice Act), or LBA; or • Behavior technician under the direction of an LaBA or unlicensed behavior analyst or assistant behavior analyst, both under required supervision; or • Physician, Licensed Psychologist, or Licensed Psychologist Associate (with required supervision as defined by Article 18G of the North Carolina Psychology Practice Act), or LBA or
97155	<ul style="list-style-type: none"> • Physician • Licensed Psychologist or Licensed Psychologist Associate (with required supervision as defined by Article 18G of the North Carolina Psychology Practice Act)

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	<ul style="list-style-type: none"> supervision as defined by Article 18G of the North Carolina Psychology Practice Act) LBA LaBA or unlicensed behavior analyst or assistant behavior analyst, both under required supervision
<p>97156 97157</p>	<ul style="list-style-type: none"> Physician Licensed Psychologist or Licensed Psychologist Associate (with required supervision as defined by Article 18G of the North Carolina Psychology Practice Act) LBA