

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

**Medicaid and Health Choice
Clinical Coverage Policy No: 8F
Amended Date: December 1, 2020**

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This clinical coverage policy has an effective date of December 1, 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.

Related Clinical Coverage Policies

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

1.0 Description of the Procedure, Product, or Service

Research-Based-Behavioral Health Treatments (RB-BHT) services are researched-based behavioral intervention services 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. RB-BHT demonstrate clinical efficacy in treating ASD: prevent or minimizes the adverse effects of ASD; and promote, to the maximum extent possible, the functioning of a beneficiary.

RB-BHT services include, 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:
 1. Adapting 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, communication, 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 (peer mediated instruction, structured play groups);
 5. Applying technological tools to change behaviors and teach skills (video modeling, tablet-based learning software);
 6. Training of parents, guardians, and caregivers on interventions consistent with the RB-BHT; and

- c. Observation and 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 Provider is in the same location, or using Telehealth in accordance with section 3.1.1, as both the individual and the paraprofessional (BCaBA or technician); and
 2. the observation is for the benefit of the individual. The Performing 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. 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

1.1 Definitions

1.1.1 Preventative

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

1.1.2 Diagnostic

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

1.1.3 Diagnosis

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

1.1.4 Therapeutic

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

1.1.5 Rehabilitative

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

1.1.6 Habilitative services

Habilitative services is defined as health care services that help a person learn, keep or improve skills and functioning for daily living. Examples include therapy for a child who isn't 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.

1.1.7 Provisional Diagnosis

Professional Diagnosis is defined as a diagnosis, for individual under three years of age, made by a licensed professional as provisional or "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 licensed 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). individuals shall have an ASD Diagnosis within six months of the provisional diagnosis.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(The term "General" found throughout this policy applies to all Medicaid and NCHC policies)

- a. An eligible beneficiary shall be enrolled in either:
 1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
 2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC 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.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

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 beneficiaries 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 beneficiaries, 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.

b. NCHC

None Apply.

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.

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, 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/>

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

NC Medicaid shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the NC Medicaid clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

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

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.1.1 Telehealth Services

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

3.1.2 Telephonic Services

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

This service delivery method is reserved for circumstances when:

- 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.

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

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

Medicaid and NCHC shall cover RB-BHT services for beneficiaries 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.

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;
- c. for beneficiaries 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 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.

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.

3.2.3 Continued Stay Criteria

Medicaid and NCHC 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; or
- b. the beneficiary continues to be at risk for regression based on current clinical assessment, history, or the tenuous nature of the functional gains, and the beneficiary meets one of the following conditions:
 1. has achieved current Treatment Plan goals and additional goals are indicated as evidenced by documented symptoms;
 2. is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the Treatment Plan;
 3. is making some progress, but the specific interventions, frequency, intensity, and location in the Treatment Plan need to be modified so that greater gains, which are consistent with the beneficiary's pre-morbid or potential level of functioning, are possible;
 4. fails to make progress or demonstrates regression in meeting goals through the interventions outlined in the Treatment. (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 functioning effectively 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 team services, or attempts to titrate RB-BHT team services downward have resulted in regression; or
 - B. there is a clinically sound expectation that the core and associated deficits of ASD persists and that ongoing treatment interventions are needed to sustain functional gains.

3.2.4 Transition or Discharge Criteria

A beneficiary shall meet at least ONE of the following to be considered for transition or discharge from a treatment program:

- a. the beneficiary ages out of the service;
- b. the family, caregiver, or beneficiary desires to discontinue services;
- c. the beneficiary who has a provisional diagnosis for ASD does not meet the diagnostic criteria for ASD (as measured by appropriate scientifically validated tools);
- d. the beneficiary and team determine that RB-BHT services are no longer needed based on the attainment of goals as identified in the Treatment Plan, no additional goals are needed, and a different level of care or level of support would adequately address current goals;

- e. 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;
- f. 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;
- g. 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;
- h. 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;
- i. 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 team services, or attempts to titrate RB-BHT team 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 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.

3.2.5 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 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 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.

3.2.6 Medicaid Additional Criteria Covered

None Apply

3.2.7 NCHC Additional Criteria Covered

None Apply

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 and NCHC 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 both Medicaid and NCHC

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

- a. time spent doing, attending or participating in recreational activities unless tied to specific planned social skill training or other therapeutic interventions related to a Treatment Plan goal;
- b. services provided to teach academic subjects or as a substitute for educational personnel, including a: teacher, teacher's aide or an academic tutor;
- c. childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- d. 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 beneficiary's issues and not listed on the eligible beneficiary's treatment plan;
- i. Treatments that are not based in scientific evidence and unproven treatments;
or
- j. any service not covered in **Section 3.0** of this policy.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply

4.2.3 NCHC Additional Criteria Not Covered

- a. In addition to the specific criteria not covered in **Subsection 4.2.1** of this policy, NCHC shall not cover: per NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
 - 1. No services for long-term care.
 - 2. No nonemergency medical transportation.
 - 3. No EPSDT.
 - 4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

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 and NCHC 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.

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 developed by a Licensed Qualified Autism Service Provider (LQASP). The Treatment Plan shall be reviewed no less than once every six months by an LQASP and modified whenever appropriate. Extension of service authorization must be received to continue coverage of the service. Services provided without prior authorization are not be considered for payment or reimbursement except in the case of retroactive Medicaid eligibility.

Medicaid and NCHC covers up to 180 calendar days for the initial authorization period based on medical necessity documented on the authorization request form and supporting documentation. Refer to **Subsection 2.1.2**.

Reauthorization

Medicaid and NCHC cover 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 beneficiaries.

For Medicaid beneficiaries who are three years of age or older, Research-Based Behavioral Health Treatment services require Prior Approval by the PIHP. The PIHP approves the plan of care and may approve or reduce or deny services.

For NCHC beneficiaries, Research-Based Behavioral Health Treatment services require Prior Approval by the State designated vendor.

For Medicaid beneficiaries under three years of age, Research-Based Behavioral Health Treatment services require Prior Approval by the PIHP 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 RB-BHT service beneficiaries shall have a behavioral, functional, and adaptive assessment. The behavioral, functional, and adaptive assessment must:

- 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.

5.3.2 Treatment Plan Development

All RB-BHT Services must be provided and supervised under an approved Treatment Plan developed by an LQASP. 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 or developmental and developmental/behavioral pediatrician, psychologist or psychological associate;
- b. occupational therapist;
- c. speech-language pathologist;
- d. clinical social worker;
- e. professional counselor;
- f. licensed marriage or family therapist; or
- g. other licensee 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 licensee. The Licensed Qualified Autism Service Provider develops the treatment plan and may also supervise or provide RB-BHT.

5.3.3 Treatment Plan

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;
- c. 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.

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.

5.3.4 Treatment Plan Reviews and Annual Rewriting

All Treatment Plans must be updated as needed and must be rewritten at least annually. At a minimum, the Treatment Plan must be reviewed by the responsible professional 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 or NCHC, providers shall ensure that their documentation is consistent with the requirements contained in this policy.

5.4.1 Responsibility for Documentation

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

- 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 (LQSP) and Certified Qualified Professional (C-QP) is not required to countersign service notes written by a staff person who does not have LQSP or C-QP status.

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 or NCHC 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 Treatment Plan;
- h. description of the intervention provided. Documentation of the intervention must accurately reflect treatment for the duration of time indicated;
- i. duration of service: Amount of time spent performing the intervention;
- j. assessment of the effectiveness of the intervention and the beneficiary's progress towards the beneficiary's goal;
- k. signature, date, and credentials or job title of the staff member who provided the service; and
- l. each service note page must be identified with the beneficiary's name, Medicaid or NCHC identification number, and record number.

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 (or dedicated vendor) Consumer Admission and Discharge Form must be submitted to the LME-MCO (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.

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

6.1 Provider Roles

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.

- a. Licensed Qualified Autism Service Provider develops the treatment plan and may also supervise or provides RB-BHT.
- b. A Certified Qualified Professional provides, supervises, or provides and supervises RB-BHT pursuant to a treatment plan developed by a Licensed Qualified Autism Service provider.
- c. A paraprofessional provides RB-BHT pursuant to a treatment plan developed by a Licensed Qualified Autism Service provider and is supervised by either a LQASP or C-QP.

In addition to the 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;
- c. demonstrate that they meet these standards by being certified by the 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

6.2 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 Licensed Qualified Autism Provider:

- a. Physician, developmental, or behavioral pediatrician;
- b. Licensed Psychologist;
- c. Licensed Psychological 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.

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. Board Certified Behavior Analyst (BCBA)
- b. Other certified or provisionally licensed professional

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).

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.

6.3 Provider Certifications

Competencies of Licensed Qualified Autism Professionals and 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).

7.0 Additional Requirements

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

7.1 Compliance

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

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All DHB'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 and NCHC funded mental health, developmental disabilities, and substance abuse services. The purpose of the audit is to ensure that these services are provided to Medicaid and NCHC beneficiaries 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 may also conduct compliance reviews and monitor provider organizations under the authority of DHB. Tribal providers are not subject to LME/MCO 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 or NCHC identification number, date(s) of service, procedure code, number of units billed in error, and reason for error.

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

8.0 Policy Implementation and History

Original Effective Date: Month Day, Year

History:

Date	Section or Subsection Amended	Change
08/15/2019	All Sections and Attachment(s)	New policy documenting current coverage for Research-Based Behavioral Health Treatment, for Medicaid and NCHC beneficiaries 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 beneficiaries 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.
	Related Clinical Coverage Policies	1-H, Telehealth, Virtual Patient Communications, and Remote Patient Monitoring
	Section 3.1.1	Added new subsection 3.1.1 Telehealth Services.
	Section 3.1.2	Added new subsection 3.1.2 Telephonic Services
	Section 3.2.5	Added new subsection 3.2.2 Telephonic-Specific Criteria
	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."
	Attachment A, Section C	Added columns to service codes indicating if the services were eligible for telehealth. Added Columns to service codes indicating if the services are available telephonically. Added "Note: Telehealth and telephonic

Date	Section or Subsection Amended	Change
		eligible services may be provided to both new and established beneficiaries by the eligible providers listed within this policy.”
	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>
	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.”

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 and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction) billed through the PIHP 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.

CPT Code(s)		Telehealth Billable Services (with GT modifier)	Telephonic Billable Services (with KX modifier)
97151	1 unit = each 15 - minute increment	Yes	No
97152	1 unit = each 15 - minute increment	Yes	No
97153	1 unit = each 15 - minute increment	Yes	No
91754	1 unit = each 15 - minute increment	Yes	No
97155	1 unit = each 15 - minute increment	Yes	No
97156	1 unit = each 15 - minute increment	Yes	If the criterial in 3.1.2 and 3.2.5 are met, the

			following services may be offered via telephonic modality.
97157	1 unit = each 15 - minute increment	Yes	If the criterial in 3.1.2 and 3.2.5 are met, the following services may be offered via telephonic modality

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.

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.

Natural settings include: a beneficiary’s primary private residence (home), place of recreation or socialization, place of community access or place of work or school. 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/>.

For NCHC refer to G.S. 108A-70.21(d), located at http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html.

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/>