Clinical Policy: Research-Based Behavioral Health Treatment (RB-BHT) for Autism Spectrum Disorder (ASD)

Reference Number: WNC.CP.109 Coding Implications
Last Review Date: 05/24 Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

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 Member. 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 member.

Policy/Criteria[1]

I. It is the policy of WellCare of North Carolina® that RB-BHT for ASD is medically necessary per the criteria below:

A. RB-BHT services are covered for Medicaid members 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 (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:

1. the Member 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;

2. the covered treatment must be medically necessary for preventing and minimizing the disabilities associated with of ASD;
3. for members under three years of age at the time services are initiated, a provisional diagnosis of ASD is accepted;
4. the Research-Based Behavioral Health Treatment being requested has clinical efficacy in treating ASD;
5. based on the current or Psychological or adaptive or other relevant assessments that informs the plan, this service is indicated;
6. this service prevents or minimizes the disability and behavioral challenges associated with ASD;
7. this service promotes the adaptive functioning of the Member;
8. 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**
9. 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.

B. Initial Process

1. 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 Member who has been diagnosed with ASD.
2. **Service Order**
   a. 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 Member's needs.
   b. 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.
   c. 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. **Assessment and Treatment Plan**
   a. All RB-BHT service members shall have a behavioral, functional, and adaptive assessment. The behavioral, functional, and adaptive assessment **must**:
      i. be based on the Member's strengths and interests; **and**

ii. describe the core and associated deficits of ASD for the Member and how those deficits impact the Member.

b. Treatment Plan Development
   i. all RB-BHT Services must be provided and supervised under an approved Treatment Plan developed by a Licensed Qualified Autism Service Provider (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 LQASP develops the treatment plan and may also supervise or provide RB-BHT.

c. The Treatment Plan must contain **ALL** of the following elements:
   i. be person-centered and developmentally appropriate with individualized goals.
   ii. describe the Member's behavioral health or developmental skills and challenges that are to be treated;
   iii. delineate an intervention plan that documents:
      a) the service type; number of hours of direct service and supervision;
      b) location of the service;
      c) 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;
      d) the frequency at which the Member's progress is evaluated and reported; **and**
      e) identifies the individual providers responsible for delivering the services. Individual provider list can be modified with the Member's and legal guardian's consent;
   iv. 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**
   v. update goals and objectives when the treatment goals and objectives are achieved or no longer appropriate;
   vi. 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 Member's consent, to include people who are important in the Member's life, such as family members, legally responsible person, professionals, friends and others identified by the Member (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.

d. **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:
    i. 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;
    ii. change in the Member's needs;
    iii. change in service provider; **and**
    iv. addition of a new service.

e. 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. **Responsibility for Documentation**
    a. The staff member who provides the service is responsible for accurately documenting the services billed and for which reimbursement is requested:
        i. the staff person who provides the service shall sign the written entry. The signature must document credentials (professionals) or a job title (paraprofessional).
        ii. a LQASP and Certified Qualified Professional (C-QP) is not required to countersign service notes written by a staff person who does not have LQASP or C-QP status.
    b. Contents of a Service Note
        i. 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) Member'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 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 Member's progress towards the Member'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 Member's name, Medicaid identification number, and record number.

C. Continued Stay Criteria

1. RB-BHT services are covered for continued stay per the criteria below:
   a. the desired outcome or level of functioning is not restored, improved, or sustained over the timeframe outlined in the Member's Treatment Plan; **or**
   b. the Member continues to be at risk for regression based on current clinical assessment, history, or the tenuous nature of the functional gains, and the Member meets **one** of the following conditions:
      i. has achieved current Treatment Plan goals and additional goals are indicated as evidenced by documented symptoms;
      ii. 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;
      iii. 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 Member's pre-morbid or potential level of functioning, are possible;
      iv. fails to make progress or demonstrates regression in meeting goals through the interventions outlined in the Treatment. (In this case, the Member 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;
      v. 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.

D. Transition or Discharge Criteria

1. A Member shall meet at least **ONE** of the following to be considered for transition or discharge from a treatment program:
   a. the Member ages out of the service;
   b. the family, caregiver, or Member desires to discontinue services;
   c. the Member who has a provisional diagnosis for ASD does not meet the diagnostic criteria for ASD (as measured by appropriate scientifically validated tools);
   d. the Member 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 Member 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 Member 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 Member 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 Member in the transition process;
   h. the Member and, if appropriate, the legally responsible person, chooses to withdraw from services and documented attempts by the program to reengage the Member with the service have not been successful;
   i. the Member 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:
      i. the Member 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**
      ii. there is a clinically sound expectation that ongoing treatment interventions are needed to sustain functional gains; **or**
   j. the Member has not demonstrated significant improvement following reassessment and several adjustments to the treatment plan, personnel or modality over at least six months **and**:
      i. alternative treatment or providers have been identified that are deemed necessary and are expected to result in greater improvement;
      ii. the Member's core and associated deficits have worsened, such that continued treatment is not anticipated to result in sustainable change; **or**
      iii. the Member is not appropriate for the service type.

2. 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 Member and the RB-BHT Team;
   b. Member's status at discharge or transition;
   c. written final evaluation summary of the Member's progress toward the goals set forth in the Treatment Team;
   d. a plan for follow-up treatment, developed in conjunction with the Member; **and**
   e. signatures of the Member 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 dedicated Vendor.
3. 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 Member and family or caregiver.

   Note: Notification to the member/Member or legal guardian of appeal rights will be provided for any denial, reduction, suspension, or termination of service.

E. Telephonic-Specific Criteria

1. Providers shall ensure that services can be safely and effectively delivered using telephonic, audio-only communication;
2. Providers shall consider the caregiver's abilities to participate in services provided using telephonic, audio-only communication;
3. 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;
4. Providers shall obtain and document verbal or written consent. In extenuating circumstances when consent is unable to be obtained, this should be documented;
5. Providers shall verify the caregiver's identity using two points of identification before initiating a telephonic, audio-only encounter; **and**
6. Providers shall ensure that Member and caregivers privacy and confidentiality is protected.

II. It is the policy of WellCare of North Carolina® that Research-Based Behavioral Health Treatment (RB-BHT) for Autism Spectrum Disorder (ASD) is **not medically necessary** per the criteria below:

A. These activities are **not** allowed or considered an activity for RB-BHT Services:

1. 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;

2. services provided to teach academic subjects or as a substitute for educational personnel, including a: teacher, teacher's aide or an academic tutor;
3. childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
4. respite care;
5. covered services that have not been rendered;
6. services not identified on the Member's authorized treatment plan;
7. services provided without prior authorization by the PHP
8. services provided to children, spouse, parents or siblings of the eligible Member under treatment or others in the eligible Member's life to address problems not directly related to the eligible Member's issues and not listed on the eligible Member's treatment plan;
9. treatments that are not based in scientific evidence and unproven treatments; **OR**
10. any service not covered as medically necessary in this policy.

Background[1]

I. 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 RBBHT; **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, 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 Native American youth and Promising Practice interventions that are culturally grounded and community driven programs that are supported by tribal communities.

II. Provider Roles

A. These services are regularly scheduled and provided by a LQASP provider, a C-QP, or a paraprofessional.

1. LQASP provider develops the treatment plan and may also supervises or provides RB-BHT.
2. 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.
3. 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.

B. In addition, the provider(s) shall:

1. 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);
2. Fulfill the requirements of 10A NCAC 27G;

3. 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**
4. Providers must have competency in Cultural Humility.

III. Provider Qualifications & Occupational Licensing Entity Regulations, and Provider Certifications: Please refer to North Carolina Medicaid State Policy Site for Clinical Coverage Policy No: 8A-10, "Clinically Managed Residential Withdrawal Management Services (ASAM 3.2 WM)," Section 6.0 at **https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies**

IV. Prior Approval

A. Prior approval is required for Research-Based Behavioral Health Treatment services. The provider shall obtain prior approval before rendering Research-Based Behavioral Health Treatment services.

B. 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 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 considered for payment or reimbursement except in the case of retroactive Medicaid eligibility.

C. The initial authorization period will be up to **180 days** and based on medical necessity documented on the authorization request form and supporting documentation.

D. Reauthorization

1. The reauthorization period will be up to **180 days** and 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.

V. Place of Service

A. 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.

B. Natural settings include: a Member's primary private residence (home), place of recreation or socialization, place of community access or place of work or school. Delivering services to a Member's natural environment must be done in a respectful manner (example, team members shall not appear at the Member's place of work without receiving permission to do so beforehand).

C. Telehealth Services

1. 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 *WNC.CP.193: Telehealth, Virtual Patient Communications, and Remote Patient Monitoring*.

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

D. Telephonic Services
1. 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.
2. 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.
3. Telephonic claims should be filed with the provider's usual place of service code(s).

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description	Telehealth Billable Services (with GT modifier)	Telephonic Billable Services (with KX modifier)
97151	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan	Yes	No
97152	Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes	Yes	No

CPT®* Codes	Description	Telehealth Billable Services (with GT modifier)	Telephonic Billable Services (with KX modifier)
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes	Yes	No
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes	Yes	No
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes	Yes	No
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes	Yes	If the criteria in I. E. and V.D. are met, the following services may be offered via telephonic modality
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes	Yes	If the criteria in I.E., and V.D. are met, the following services may be offered via telephonic modality

*Modifier **GT** - Appended to the CPT 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.
*Modifier **KX** - Appended to the CPT code to indicate that a service has been provided via telephonic, audio-only communication.

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	01/21	06/21
Added Telehealth and Telephonic Services criteria. Added Telehealth and Telephonic Billable Services criteria to CPT code grid.	07/21	08/21
Reviewed CPT codes.	06/22	08/22

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
NCHC verbiage removed from NC Guidance Verbiage.	03/23	03/23
Annual Review. CPT codes reviewed.	05/23	05/23
Annual Review. HCPCS and ICD-10 tables removed. Background III. Changed "Provider Qualifications & Occupational Licensing Entity Regulations, and Provider Certifications" to: Please refer to North Carolina Medicaid State Policy Site for Clinical Coverage Policy No: 8A-10, "Clinically Managed Residential Withdrawal Management Services (ASAM 3.2 WM)," Section 6.0 at https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies."	05/24	05/24

References

1. State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No: 8F Research-Based Behavioral Health Treatment (RB-BHT) for Autism Spectrum Disorder (ASD). Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published April 1, 2023. Accessed February 6, 2024.

North Carolina Guidance

Eligibility Requirements

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.

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, 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.

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/

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.

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).

Claims-Related Information
Provider(s) shall comply with the NC Tracks 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 - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   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.
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.
   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
d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.