Clinical Communication Bulletin 99

To: All Providers

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Date: **March 3, 2026**

Subject: Research Based-Behavioral Health Treatment (RB-BHT)

BASED-BEHAVIORAL HEALTH TREATMENT (RB-BHT)

The purpose of this RB-BHT Medical Necessity Clinical Communication Bulletin is to support consistent, accurate, and policy-aligned determinations for RB-BHT authorization requests. This bulletin serves as a clinical and operational tool designed to assist providers when submitting Treatment Authorization Requests (TARs) for RB-BHT as defined in Clinical Coverage Policy 8F, Trillium's Benefit Plan and EPSDT requirements.

INITIAL AND CONCURRENT AUTHORIZATION PARAMETERS

TARs for both initial and concurrent authorization may be approved for up to 180 calendar days. The number of RB-BHT units authorized is determined on an individualized basis and must be supported by a comprehensive assessment and treatment plan. Authorization decisions focus on the members' specific needs, functional impairments, and goals to promote adaptive functioning and reduce disability, rather than a standardized or preset number of service hours.

There is no fixed number of units associated with a particular "level" of ASD, as individuals with the same diagnostic level may present with varying strengths, challenges, and service needs. The following guidelines and authorization parameters are intended to reflect evidence-based practices and serve as general clinical guidance, not absolute limits:

- 97151 initial and concurrent: Up to 32 units for 6-month period
- 97152 initial and concurrent: Up to 6 hours for 6 months
- 97153, 97154, and 97155 initial and concurrent: up to 160 units (40 hours)/week for 6 months

- 97156 and 97157 initial and concurrent: 12 units (3 hours) per week for 6 months

Required Clinical Documentation

The following documentation must be submitted at the time of the treatment authorization request (TAR):

- A comprehensive psychological evaluation, psychological assessment or diagnostic assessment that confirms an ASD and includes documentation of the use of scientifically validated diagnostic tool(s) incorporated into the assessment findings.
- For members under the age of three at the time-of-service initiation, a provisional ASD is acceptable; however, a comprehensive diagnostic evaluation confirming ASD must be completed within six months of the provisional diagnosis.
- A current, signed and dated individualized treatment plan aligned with identified clinical needs, parental involvement/participation, and medical necessity requirements.
- A valid signed and dated service order.

Assessments and Scientific Validated Screening Tools

The assessment must include an official Autism Spectrum Disorder (ASD) diagnosis. For individuals under the age of three at the time-of-service initiation, a provisional diagnosis of ASD is acceptable. However, a comprehensive diagnostic evaluation confirming ASD must be completed within six months of the provisional diagnosis. The psychological evaluation or assessment must include a behavioral, functional, and adaptive assessment. These behavioral, functional and adaptive assessments must be based upon the member's strengths, interests, and describe the core and associated deficits of ASD for the member and how those deficits impact the member (CCP 8F, Section 5.3.1). Examples of scientifically validated diagnostic tools for the diagnosis of ASD include ADOS-2, ADI-R, or CARS-2. Other widely used screenings include (i.e.) GARS-3, Vineland-3, ABAS-3, or BASC-3.

Ongoing best practice assessments should include the following:

- Review of the Comprehensive Assessment and Addendums: Initial and ongoing objective assessments that describe baseline behavior levels to inform specific treatment goals. When goals level up a new assessment should be completed as the purpose of treatment has changed.

- **Functional Focus:** A focus on understanding the "why" (function) behind a behavior—such as escape, attention, or sensory needs—to replace problem behaviors with appropriate social skills. This should be well documented in treatment plan and progress notes for continued stay following the initial authorization.
- **Small Unit Building:** Breaking down complex behaviors into small, manageable units that build toward larger changes in independence. This should be incorporated into both the assessment addendum, treatment planning and notes such that the reviewer can see the golden thread of improvement for the member across the entire treatment episode the assessment, treatment plan and progress notes should demonstrate and evolution over the course of treatment if they are stagnant and don't change this is not RB-BHT.
- **Direct Observation and Data:** Continuous collection and analysis of direct observational data to monitor progress and adjust treatment protocols in real-time. Evidence of this data should be provided for reauthorization and demonstrate progress or adjustments to achieve progress.
- **Evidence of Generalization Across Settings:** Interventions and documentation should occur in multiple environments (home, school, community) to ensure that skills learned in therapy are maintained and applied in real-world situations with care givers, teachers etc.

Treatment Plan

The treatment plan must be reviewed at least every six months and updated as clinically indicated. Plans must be formally rewritten annually. Each treatment plan must clearly document the member's behavioral and/or developmental skill challenges, prescribed service type including telehealth as applicable, authorized hours of direct service and supervision, service location, and parental involvement and participation.

In addition, treatment plans must include short-term, measurable goals and objectives; current goals in progress; discharge planning information; and relevant whole-personal care planning and coordination. This includes documented linkages to the full continuum of ASD and related services as applicable to the member's individualized needs, such as speech therapy, occupational therapy and other supportive interventions. Plans must be signed and dated by both the clinician and guardian.

Service Order Requirements

Must be signed by one of the following licensed professionals:

MD (Medical Doctor)

DO (Doctor of Osteopathy)

PsyD (Doctor of Psychology) Psychologist

PhD (Doctor of Philosophy) Psychologist

Service orders are valid for one year and authorization cannot extend beyond its expiration date.

Summary Checklist for Providers

To support timely and efficient review of RB-BHT service requests, providers are required to submit the following clinical documentation at the time of the authorization request:

- ASD diagnosis confirmed in assessment or psychological evaluation, including verification of the use of scientifically validated diagnostic tools. Also, for individuals under the age of three at the time-of-service initiation, a provisional diagnosis of ASD is acceptable. However, a comprehensive diagnostic evaluation confirming ASD must be completed within six months of the provisional diagnosis.
- Treatment Plan (6-month treatment plan included, if applicable with current goals, details of service, and signatures/dates of clinician and guardian). Annual rewrite required.
- Service Order or Referral signed and dated by either MD/DO/PsyD/PhD.
- Psychological Evaluation/Assessment present with clinician's signature/date/credentials.

All required documentation must be uploaded at the time of TAR submission.

As a reminder, handwritten signatures require handwritten dates by the signatory. Electronic signatures must follow authentication requirements of electronic signature and date stamp. For additional guidance, please refer to the NCDHHS Records Management and Documentation Manual, July 2025 update.

WHEN EPSDT APPLIES

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 beneficiaries 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 identified through a screening examination.

Under EPSDT, services can go beyond the normal Medicaid limits when the requested service is medically necessary, support the member's health improvement, or help maintain the child's functioning. The authorized length of stay for both initial and reauthorization requests for RB-BHT services may be approved for up to 180 days. Requests exceeding 180 days and/or those requiring 2:1 additional staffing support are subject to EPSDT review requirements. UM reviewers will select the EPSDT indicator when reviewing and approving the TARs under EPSDT criteria. UM clinicians also document EPSDT approvals within the TAR clinical notes to providers. In addition, providers may view confirmation of EPSDT approvals by selecting the authorization number in Provider Direct. Providers are likewise responsible for selecting the EPSDT indicator when submitting claims associated with TARs approved under EPSDT.

When submitting a claim for EPSDT, the claim should be submitted with the appropriate EPSDT indicator per the NUCC CMS 1500 and NUBC UB 04 claim form billing guidelines. For electronic form submissions, be sure to include the appropriate EPSDT indicator in the EDI loop/segment per the X128371/837P guidelines. See Clinical Communication Bulletin 81.

GT MODIFIER

All RB-BHT service codes require prior authorization, including services billed with the GT modifier. Providers may submit a treatment authorization request (TAR) to add the GT modifier to previously approved base service codes using the same authorized dates of service. For all future authorization requests, providers must include all requested service codes, inclusive of applicable modifiers, at the time of submission.

Thank you for your attention to this communication. All questions related to this Clinical Communication Bulletin can be sent to UM@TrilliumNC.org. Questions will be answered as quickly as possible