Trillium HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

2024-2025 Medicaid Child Behavioral Health Benefit Plan

Service Code(s):	***Services Included (Sorted by Alphabetical Order):***
H2012HA	Child and Adolescent Day Treatment
H2022U5U1, H2022U5U2, H2022U5U3	Family Centered Treatment
H0032U5	High Fidelity Wraparound
H2022	Intensive In-Home
H2033HA, H2033HAU1	Multisystemic Therapy
H0035	Partial Hospitalization
911	Psychiatric Residential Treatment Facilities
97151, 97152, 97153, 97154, 97155, 97156, 97157	Research-Based Behavioral Health Treatment for Autism Spectrum Disorder, Adaptive Behavior Treatment Services
S5145, H2020	Residential Treatment Services: Level II
H0019HQ, H0019TJ	Residential Treatment Services: Level III, Sexually Aggressive Youth (SAY) Program
H0019HQ, H0019TJ	Residential Treatment Services: Level III
H0019HK, H0019UR	Residential Treatment Services: Level IV

Codes / modifier combinations not mentioned for specialized services will be found within contracts.
For Medicaid services, Child services are available through age 21. Adult services are available from age 21 and older.
An Interstate Compact (ICPC) must be completed on a child being admitted to an Out-of-State facility: Part A prior to admission and Part B once admitted.
When state Medicaid coverage provisions conflict with the coverage provisions in a Trillium policy, state Medicaid coverage provisions take precedence.

Person-Centered Plan Requirements & Guidance

Providers can use the PCP template or develop their own template, but the PCP ***must*** contain all the required elements: 1) Assessment of life domains; 2) Person-Centered Interview Questions; 3) An action plan; 4) An enhanced crisis intervention plan, and; 5) A signature page. The PCP should be based on a comprehensive assessment that examines the individual's symptoms, behaviors, needs and preferences across the life domains listed below. Additional info can be found on the NCDHHS Person-Centered Planning Training webpage (PCP Guide). See the JCB #445 Timelines for Implementation for the implementation requirements for the new PCP guidance and templates.

Life Domains (PCP Guide)

Each life domain should provide a written picture of what is currently happening, what the individual's vision for a preferred life is for that area, and what the provider is doing to support the individual to move closer to living their preferred life.

- *Daily Life and Employment Domain*: What a person does as part of everyday life.
- *Community Living Domain*: Where and how someone lives.
- *Safety and Security Domain*: Staying safe and secure (finances, emergencies, relationships, neighborhood, legal rights, etc.).
- *Healthy Living Domain*: Managing and accessing health care and staying well.
- *Social and Spirituality Domain*: Building/strengthening friendships and relationships, cultural beliefs, and faith community.
- *Citizenship and Advocacy Domain*: Building valued roles, understanding personal rights, making choices, sexual orientation, self-identification, setting goals, assuming responsibility and driving how one's own life is lived.

Person-Centered Interview Questions (PCP Guide)

These identify what the person wants to work on, what they would like to accomplish, their identified strengths, and any identified obstacles preventing them from reaching their goals.

Action Plan (PCP Guide)

The Action Plan section of the PCP includes the individual's long-term goal, short-term goals, and interventions or the action steps to be taken to achieve these goals. For each desired long-term goal, the Action Plan will include short-term goal(s) as well as interventions.

- *Long-Term Goal Development*: what motivates the person to engage in services and make changes. These are personal to that individual, often reflect one or more Life Domains, and typically take time to achieve. Ideally, long-term goals are oriented toward quality-of-life priorities and not only the management of health conditions and symptoms.
- Short-Term Goals: help the person move closer to achieving their long-term goals. They reflect concrete changes in functioning/skills/activities that are meaningful to the person and are proof they are making progress. Short-term goals build on strengths

while also addressing identified needs from the assessment that interfere with the attainment of the valued, long-term life goal(s). Short-term goals are written in SMART (Specific/Straightforward/Simple, Measurable, Achievable, Relevant, and Time-Limited) language.

- Interventions: reflect how all team members contribute to helping the person achieve their short-term goals. Interventions are the specific tasks the provider and individual agree on. The language of interventions should include: WHO is offering the intervention/support, WHAT specifically will be provided or done (e.g., title of service or action), WHEN it is being offered – frequency and duration (e.g., once a month for 3 months), and WHY it is needed (i.e., how the intervention relates to the individual's specific goal).

Enhanced Crisis Intervention Plan (PCP Guide)

A crisis plan includes supports/interventions aimed at preventing a crisis and the supports/interventions to employ if there is a crisis. It must include:

- Significant event(s) that may create increased stress and trigger the onset of a crisis.
- Early warning signs which indicate a possible upcoming crisis.
- Crisis prevention and early intervention strategies
- Strategies for crisis response and stabilization
- Specific recommendations for interacting with the person receiving a crisis service.
- Diagnosis and insurance information,
- Name and contact information for medical and mental health provider
- List of medications including doses and frequency, allergies, and other medical and dental concerns.
- Living situation and planning for any pets and people, etc. in case of a crisis if applicable.
- Employment/ Educational status and plan for notification if applicable
- Preferred method of communication and language.
- Names and contact information of formal and informal support persons
- Suicide prevention and intervention plan, behavior plan, youth in transition plan and Psychiatric Advance Directive (PAD), if applicable.
- Crisis follow-up planning to include: 1) The primary contact who will coordinate care if the individual requires inpatient or other specialized care; 2) Name of the person who will visit the individual while hospitalized, and; 3) Provider responsible to lead a review/debriefing following a crisis and the timeframe.

Signature Page (PCP Guide)

Signatures are authenticated when the individual signing enters the date next to their signature. Check boxes left blank on the signature pages of the PCP will be returned as incomplete. A signature page must include:

- Person Receiving Services - Dated signature is required when the person is his/her own legally responsible person. A provider may not bill Medicaid for services until this signature is acquired if the individual is his or her own legally responsible person.
- Legally Responsible Person - Dated signature when the person receiving services is not his/her own LRP. A provider may not bill Medicaid for services until this signature is acquired, when applicable.
- Person Responsible for the Plan - Dated signature is required. Inclusion of the required information on the signature page of the PCP template by the Person Responsible for the Plan is also required for individuals under the age of 21 (Medicaid) or under age 18 (State) who are receiving enhanced services and are actively involved with the Department of Juvenile Justice and Delinquency Prevention or the Criminal Court System.
- Service Order/Confirmation of Medical Necessity - Dated signature is required, plus confirmation of medical necessity, indication of whether review of the comprehensive clinical assessment occurred, and indication if the LP signing the service order had direct contact with the individual.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is the federal law that says Medicaid must provide all medically necessary health care services to Medicaid-eligible children. Even if a service is not covered under the NC Medicaid State Plan, it can be covered for members under twenty-one (21) years of age if the service is listed at 1905(a) of the Social Security Act and if all EPSDT criteria are met. Trillium does not require prior authorization for preventive care (early and periodic screens/wellness visits) for Medicaid members less than twenty-one (21) years of age. All required EPSDT screenings and services are available without prior authorization. Trillium may require prior authorization for other diagnostic and treatment products and services provided under EPSDT.

Trillium requires all providers to comply with the Division of Health Benefits (DHB) standards for the timely provision of EPSDT services, meaning a member must have a scheduled appointment for an EPSDT service no more than six (6) calendar weeks from the date of the request for an appointment. Trillium requires direct enrolled behavioral health providers to coordinate with primary care providers and specialists conducting EPSDT screenings.

A service can only be covered under EPSDT if all criteria specified below are met.

1. EPSDT services must be coverable within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].
2. The service must be medically necessary to correct or improve a defect, physical or mental illness, or a condition [health problem] diagnosed by the member's physician, therapist, or other Licensed practitioner.
3. The requested service must be determined to be medical in nature.
4. The service must be safe, effective, and generally recognized as an accepted method of medical practice or treatment.
5. The service must not be experimental/investigational.

Requests for EPSDT services do not have to be labeled as such. Any proper request for services for a member under twenty-one (21) years of age is a request for EPSDT services. When Trillium reviews a covered Medicaid service request for prior authorization for an individual under twenty-one (21) years of age, the reviewer applies the EPSDT criteria to the review.

EPDST does not eliminate the requirement for prior authorization if prior authorization is required. There is no retroactive prior authorization for services that require prior authorization. Services delivered without prior authorization will be denied. Requests for prior authorization for services must be fully documented to show medical necessity. This requires current information from the member's physician, other licensed clinicians, the requesting qualified provider, and/or family members or legal representative. If this information is not provided, Trillium may attempt to obtain the needed information, which could delay the prior authorization decision. While a Medicaid EPSDT request is under review, the UM Clinician may suggest alternative services that may be better suited to meet the child's needs, engage in clinical or educational discussions with the Legally Responsible Person (LRP) or providers, or engage in informal attempts to resolve member concerns as long as the Clinician makes clear that the member has the right to request authorization of the services he or she wants to request The decision to approve or deny the request will be based on the member's medical need for the service to correct or ameliorate a defect, physical [or] mental illness, or condition [health condition]. The final determination of medical necessity, per criteria specified in 42 U.S.C. § 1396d(r) and 42 C.F.R. §§ 441.50-62, is the responsibility of Trillium.

The specific numerical limits (number of hours, number of visits, or other limitations on scope, amount or frequency) in DHB clinical coverage policies, service definitions, or billing codes do not apply to members under twenty-one (21) years of age if more hours or visits of the requested service are medically necessary to correct or improve a defect, physical or mental illness, or other health condition. Other restrictions in the clinical coverage policies, such as the location of the service, prohibitions on multiple services on the same day or at the same time must also be waived under EPSDT if the services are medically necessary to correct or improve a defect, physical or mental illness, or other health condition.

To request a service under EPSDT, submit a TAR and upload the EPSDT non-covered form as part of the clinical documents for review. EPSDT items and services include:

Child First Services (H2022 HE: Monthly Service, H2022 HE U1: Encounters)
Child First is an intensive, early childhood, two-generation, home visiting intervention that works with the most vulnerable young children (prenatal through age five years) and their families. The goal is to heal and protect children from trauma and adversity.

Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source
Child and Adolescent Day Treatment Code(s): H2012HA	This is a structured tx service in a licensed facility for youth and their families that builds on strengths and addresses identified needs. This service is designed to serve children who, as a result of their mental health or substance use disorder tx needs, are unable to benefit from participation in academic or vocational services at a developmentally appropriate level in a traditional school or work setting. The provider implements therapeutic interventions that are coordinated with the member's academic or vocational services available through enrollment in an educational setting.	**Pass-Through Period:** Prior authorization is not required for this service. **Maintained in the Record (not all inclusive):** **1.** CCA: Required, to include an ASAM Score supported with detailed clinical documentation on each of the six ASAM dimensions (if applicable). **3.** Complete PCP, reviewed as applicable. **4.** Service Order, signed by an MD, DO, PA, NP, or a Licensed Psychologist. **5.** Child/Adolescent Discharge/Transition Plan **6.** IEP/ 504 Plan **7.** Behavioral Plan **8.** School Suspension Records	**Length of Stay**: This is a time limited service, and services should be titrated based on the transition plan. **Units**: One unit =1 hour. **Age Group**: Children & Adolescents **Level of Care**: ASAM Level of 2.1 (if applicable). While the LOCUS/ CALOCUS are specifically no longer required, providers are still expected to use a standardized assessment tool when evaluating an individual for treatment services. **Service Specifics, Limitations, & Exclusions (not all inclusive)**: **1.** CADT services cannot be provided during the same auth period as: IIH; MST; Individual, Group and Family therapy; SAIOP; Child Residential Tx: Level II Program Type through Level IV; PRTF; Substance Abuse Residential Services, or; Inpatient Hospitalization. **2.** CADT programs may not operate as simply an after-school program. **3.** CADT programs may not operate as simply an after-school program.	Clinical Coverage Policy 8A: Enhanced Mental Health and Substance Abuse Services, Child and Adolescent Day Treatment (MHSA) section (CCP 8A) APSM 45-2 Records Management and Documentation Manuals PCP Guidance Documents & Templates Child/Adolescent Discharge/ Transition Plan

Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source
Family Centered Treatment (FCT) Code(s): **H2022 U5 U1**: FCT Service **H2022 U5 U2**: 3 Month Outcome **H2022 U5 U3**: 6 Month Outcome	This is a comprehensive evidence-based model of intensive in-home tx for at risk youth and their families. Designed to promote permanency goals, FCT treats the youth and his/her family through individualized therapeutic interventions. All phases of FCT involve the family intensively in tx. FCT therapists are to be available 24/7 to support the youth and family when needed. The objective is to provide an alternative to out-of-home placements, minimize the length of stay in out-of-home placements, and reduce the risk of additional out-of-home placements by improving child/youth and family functioning.	**Pass-Through Period:** No prior authorization required for the initial 6 calendar months of tx. **Initial Requests (after pass-through)**: **1.** TAR: Prior authorization is required beyond the unmanaged limit. **2.** CCA: Required **3.** PCP: Required **4.** Service Order: Required, signed by a physician, LP, PA, or nurse QP. **5.** Submission of applicable records that support the member has met the medical necessity criteria. **Reauthorization Requests:** **1.** TAR: prior authorization required. **2.** Complete PCP: recently reviewed detailing the member's progress with the service **3.** Submission of applicable records that support the member has met the medical necessity criteria.	**Length of Stay**: **1.** National target standards are 6 months. **2.** Expected Outcomes Include: Decrease in crisis episodes and inpatient stays, decrease the length of stay in crisis and inpatient facilities, and a decrease in Emergency Room Visits. **Units**: **1.** FCT Service: 1 unit = 30 days **2.** Post Discharge Outcome Payment: 1 unit = 1 outcome **Age Group**: Children & Adolescents **Level of Care**: While the LOCUS/ CALOCUS are specifically no longer required, providers are still expected to use a standardized assessment tool when evaluating an individual for treatment services. **Service Specifics, Limitations, & Exclusions (not all inclusive)**: **1.** FCT services cannot be provided during the same auth period as: IIH; MST; Intercept; Individual, Group and Family therapy. **2.** Eligibility for Outcome Payments dependent upon the following: • Enrolled in FCT for at least 60 days • No inpatient admissions • No residential Level II or higher from discharge (planned or unplanned) • No return to FCT, admission to IIH or MST.	Family Centered Treatment In-Lieu Of Service Definition APSM 45-2 Records Management and Documentation Manuals PCP Guidance Documents & Templates

Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source
High Fidelity Wraparound (HFW) Code(s): H0032 U5	High Fidelity Wraparound (HFW) is an intensive, team-based, person-centered service that provides coordinated, integrated, family-driven care to meet the complex needs of youth/young adults who are involved with multiple systems (e.g. mental health, child welfare, juvenile/criminal justice, special education), who are experiencing serious emotional or behavioral difficulties, have dual diagnosis (MH and/or SUD, and IDD) with complex needs, and are at risk of placement in therapeutic residential settings, or other institutional settings, or have experienced multiple crisis events.	**Pass-Through Period:** No prior authorization (NPA) is required for the first 12 months of treatment. Prior authorization is required for any services provided after the initial 12-month NPA period. **Initial Requests (after pass-through):** **1.** TAR: Prior authorization is required **2.** CCA: Required **3.** Complete PCP or the Wraparound Plan of Care: Required. Due to the complex nature and urgency of admission, a PCP within 30 days of initial authorization is permitted. When receiving another enhanced service, the PCP must include HFW. **4.** Service Order: Required **5.** Submission of applicable records that support the member has met the medical necessity criteria. **Reauthorization Requests**: **1.** TAR: prior authorization required **2.** Complete PCP: recently reviewed detailing the member's progress with the service. **3.** Submission of applicable records that support the member has met the medical necessity criteria.	**Length of Stay**: **1.** Targeted Length of service is up to 12 months. Maximum of 18 months. **2.** It is expected that Phase 1 (Engagement/ Team Prep) and Phase 2 (Plan Development) will be completed, and Plan Implementation (Phase 3) will be initiated within 90 days. **3.** The initial request following the NPA period may be for up to 6 months. **Units**: **1.** One unit = 1 month **Age Group**: Children & Adolescents (ages 3 – 20) with Serious Emotional Disturbance (SED) or Serious Mental Illness (SMI) **Level of Care**: While the LOCUS/ CALOCUS are specifically no longer required, providers are still expected to use a standardized assessment tool when evaluating an individual for treatment services. **Service Specifics, Limitations, & Exclusions (not all inclusive)**: **1.** The following cannot be provided during the same auth period as HFW: CST; ACT; TCM; TFC, and; Substance Abuse residential services. **2.** When provided with another tx service that includes case management functions, the HFW service plan must delineate roles and responsibilities of each service to ensure there is not duplication of service delivery. **3.** HFW activities are grouped into four phases: 1) Engagement and Team Prep (2-4 weeks); 2) Plan Dev (1-2 weeks); 3) Plan Implementation (2-12 months), and; 4) Transition (typically 1 month).	High Fidelity Wraparound In-Lieu Of Service Definition APSM 45-2 Records Management and Documentation Manuals PCP Guidance Documents & Templates

Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source
Intensive In-Home (IIH) Code(s): H2022	Intensive In-Home (IIH) service is a team approach designed to address the identified needs of children and adolescents who, due to serious and chronic symptoms of an emotional, behavioral, or substance use disorder, are unable to remain stable in the community without intensive interventions. This is a time-limited, intensive child and family intervention based on the clinical needs of the member. Services are authorized for one individual child in the family and the parent or caregiver must be an active participant in the treatment.	**Initial Requests**: **1.** TAR: Prior authorization is required **2.** CCA: Required **3.** Complete PCP: Required **4.** Service Order: Required, signed by MD, DO, NP, PA, or a Licensed Psychologist. **5.** Child/Adolescent Discharge/ Transition Plan **6.** Submission of applicable records that support the member has met the medical necessity criteria. **Reauthorization Requests**: **1.** TAR: prior authorization required **2.** Complete PCP: recently reviewed detailing the member's progress with the service. **3.** Submission of applicable records that support the member has met the medical necessity criteria.	**Length of Stay**: **1.** Up to 60 days per authorization **2.** It is the expectation that service frequency shall decrease over time: at least 12 face-to-face contacts are required in the 1st month, and at least 6 face-to face contacts per month are required in the 2nd & 3rd months. **Units**: **1.** One unit = 1 event. One event = a contact of at least 2 hours. **2.** Typically 16 units per month for the initial auth, with reauthorizations titrating downward. **Age Group**: Children & Adolescents **Level of Care**: ASAM Level 2.1 (if applicable). While the LOCUS/ CALOCUS are specifically no longer required, providers are still expected to use a standardized assessment tool when evaluating an individual for treatment services. **Service Specifics, Limitations, & Exclusions (not all inclusive)**: **1.** IIH services cannot be provided during the same auth period as: a) MST; b) CADT; c) Individual, Group and Family therapy; d) SAIOP; e) Child Residential Tx: Level II Program Type through Level IV; f) PRTF; or g) Substance Abuse Residential Services	Clinical Coverage Policy No 8A: Enhanced Mental Health and Substance Abuse Services, Intensive In-Home Services section APSM 45-2 Records Management and Documentation Manuals PCP Guidance Documents & Templates Child/Adolescent Discharge/ Transition Plan

Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source
Multisystemic Therapy (MST) Code(s): **H2033 HA**: Multisystemic Therapy **H2033 HA U1**: Shadow Claim	This is a program designed for youth between the ages 7 through 19 who: a) have antisocial, aggressive or violent behaviors; b) are at risk of out-of-home placement due to delinquency; c) adjudicated youth returning from out-of-home placement; d) chronic or violent juvenile offenders; or e) youth with serious emotional disturbances or a substance use disorder and their families. MST provides an intensive model of tx based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. The purpose of this program is to keep youth in the home by delivering an intensive therapy to the family within the home.	**Pass-Through Period:** Prior authorization is not required for this service. **Maintained in the Record (not all inclusive):** **1.** CCA: Required. **2.** Complete PCP: Required. The amount, duration, and frequency of the service must be included. PCP should be reviewed and detail the member's progress on a regular basis. **3.** Service Order: Required, signed by a physician, PA, NP, or a Licensed Psychologist.	**Length of Stay**: The duration of MST is typically 3 to 5 months. **Units**: One unit = 1 tx episode **Age Group**: Children & Adolescents (Age 7 through 19) **Level of Care**: ASAM Level 2.1 (if applicable). While the LOCUS/ CALOCUS are specifically no longer required, providers are still expected to use a standardized assessment tool when evaluating an individual for treatment services. **Service Specifics, Limitations, & Exclusions (not all inclusive)**: **1.** MST services cannot be provided during the same auth period as: CADT; Hourly Respite; Individual, Group and Family therapy; SAIOP; Child Residential Tx: Level II Program Type through Level IV; or Substance Abuse Residential Services	Clinical Coverage Policy No 8A: Enhanced Mental Health and Substance Abuse Services, Multisystemic Therapy (MST) Section APSM 45-2 Records Management and Documentation Manuals PCP Guidance Documents & Templates JCB #J371: Multisystemic Therapy (MST) Services Eligibility MCO Communication Bulletin #J086

Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source
Partial Hospitalization Code(s): H0035	A short-term service for acutely mentally ill children or adults, which provides a broad range of intensive therapeutic approaches which may include: group activities or therapy, individual therapy, recreational therapy, community living skills or training, increases the individual's ability to relate to others and to function appropriately, coping skills, medical services. This service is designed to prevent hospitalization or to serve as an interim step for those leaving an inpatient facility.	**Pass-Through Period:** Prior authorization is not required for the first 7 days (7 units) **Initial Requests (after pass-through)**: **1.** TAR: Prior authorization is required. **2.** CCA: Required **3.** Complete PCP: Required. The amount, duration, and frequency of services must be included. If limited information is available at admission, staff shall document on the PCP whatever is known and update it when additional information becomes available. **4.** Service Order: Required, signed by a physician, doctoral level licensed psychologist, psychiatric NP, psychiatric clinical nurse specialist. **5.** Submission of applicable records that support the member has met the medical necessity criteria. **Reauthorization Requests**: **1.** TAR: prior authorization required. **2.** Complete PCP: recently reviewed detailing the member's progress with the service. **3.** Submission of applicable records that support the member has met the medical necessity criteria.	**Length of Stay**: **1.** Initial (after pass-through) and Reauthorization requests shall not exceed 7 calendar days. **Units**: **1.** One unit = 1 event **2.** This is day or night service provided a minimum of 4 hrs/day, 5 days/week, and 12 months/year (excluding transportation time). Excludes legal or governing body designated holidays. **Age Group**: Children & Adolescents **Level of Care**: While the LOCUS/ CALOCUS are specifically no longer required, providers are still expected to use a standardized assessment tool when evaluating an individual for treatment services.	Clinical Coverage Policy 8A: Enhanced Mental Health and Substance Abuse Services, Partial Hospitalization section APSM 45-2 Records Management and Documentation Manuals PCP Guidance Documents & Templates

Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source
Psychiatric Residential Treatment Facilities (PRTF) Code(s): 911	Service provides non-acute inpatient facility care for Medicaid beneficiaries under 21 years of age who have a mental illness or a substance use disorder and need 24-hour supervision and specialized interventions.	**Initial Requests**: **1.** TAR: Prior authorization is required **2.** CON: Required, completed within the last 15 days **3.** CCA: Required, must have been completed within 30 days of admission and have the service indicated **OR** a Psychological Assessment completed within the last year that recommends PRTF. Either assessment must include an ASAM Score supported with detailed clinical documentation on each of the six ASAM dimensions (if applicable). **4.** Evidence of Family Engagement: Required **5.** Discharge/Transition Plan: Required, to include a step-down plan **6.** Out-of-State Paperwork: Required, if applicable. **7.** Submission of applicable records that support the member has met the medical necessity criteria. **Reauthorization Requests**: **1.** TAR: prior authorization required **2.** Complete PCP: recently reviewed detailing the member's progress with the service. **3.** Updated ASAM Score: Required, if applicable **4.** Family Engagement Plan: Required **OR** Visiting Resources, if there has been no family engagement **5.** Child/Adolescent Discharge/ Transition Plan: Required **6.** Submission of applicable records that support the member has met the medical necessity criteria.	**Length of Stay**: Up to 30 days for all authorization requests. **Units**: **1.** One unit = 1 day **Age Group**: Children & Adolescents (Service is available to youth under the age of 21. Continued tx can be provided until the member's 22nd birthday when medically necessary.) **Level of Care**: While the LOCUS/ CALOCUS are specifically no longer required, providers are still expected to use a standardized assessment tool when evaluating an individual for treatment services. **Service Specifics, Limitations, & Exclusions (not all inclusive)**: **1.** MCD will not cover PRTF services that are ordered by the court when medical necessity criteria are not met. **2.** MCD will cover not cover PRTF services when the primary issues are social or economic, such as placement issues.	Clinical Coverage Policy No 8D-1: Psychiatric Residential Treatment Facilities APSM 45-2 Records Management and Documentation Manuals PCP Guidance Documents & Templates Child/Adolescent Discharge/ Transition Plan MCO Communication Bulletin #72

Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source
Research-Based Behavioral Health Treatment (RB-BHT) For Autism Spectrum Disorder (ASD) Code(s): **97151**: Comprehensive Assessment- Billed by LQASP **97152**: Assessment Follow Up- Billed by LQASP **97153**: ABA provided by LQASP, C-QP, Paraprofessional **97154**: ABA Group provided by LQASP, C-QP, Paraprofessional **97155**: Adaptive Behavior Treatment with Protocol Modification **97156**: Parent Training without Child provided by LQASP, C-QP, Paraprofessional (Telephonic billable w/ KX modifier, provided criteria in 3.1.2 and 3.2.5 are met) **97157**: Parent Training Group provided by LQASP, C-QP, Paraprofessional (Telephonic billable w/ KX modifier, provided criteria in 3.1.2 and 3.2.5 are met) The GT (Telehealth) modifier can be used with all these service codes.	Services are researched-based behavioral interventions 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.	**Pass-Through Period:** Prior authorization is not required for this service. **Maintained in the Record (not all inclusive):** **1.** Service Order: Required, signed by an MD, DO or a licensed psychologist. **2.** Dx: Definitive ASD dx documentation required utilizing a scientifically validated diagnostic tool for diagnosis of ASD. For members under 3, a provisional diagnosis of ASD is acceptable. **3.** Behavioral, Adaptive, or Functional Assessment: Required **4.** Assessment: A copy of the assessment completed under 97151 is required. **5.** Complete Tx Plan: Required, developed and signed by a LQASP and legally responsible person. Must be reviewed no less than once every 6 months and rewritten at least annually. **6.** Submission of applicable records that support the member has met the medical necessity criteria.	**Units**: One unit = 15 minutes **Age Group**: Children & Adolescents **Level of Care**: While the LOCUS/ CALOCUS are specifically no longer required, providers are still expected to use a standardized assessment tool when evaluating an individual for treatment services. **Service Specifics, Limitations, & Exclusions (not all inclusive)**: **1.** RB-BHT services are 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.	Clinical Coverage Policy No 8F: Research-Based Behavioral Health Treatment (RB-BHT) For Autism Spectrum Disorder (ASD) APSM 45-2 Records Management and Documentation Manuals PCP Guidance Documents & Templates

Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source
Residential Treatment Services: Level II/ Family/ Program Type Code(s): **S5145** (Family) **H2020** (Group Home)	Residential treatment provides a structured, therapeutic, and supervised environment to improve the level of functioning for beneficiaries. There are four levels of residential treatment. Residential Treatment Level II Service provides a moderate to highly structured and supervised environment in a family or program setting.	**Initial Requests:** **1.** TAR: Prior authorization is required, including all items on entrance criteria. **2.** CCA: Required, completed in the 30 days prior to admission and having this service indicated **OR** a signed Continued Need Review (CNR) assessment. Assessment must include an ASAM Score supported with detailed clinical documentation on each of the six ASAM dimensions (if applicable). **3.** Service Order: Required, signed primary care physician, psychiatrist, or a licensed psychologist **4.** Submission of applicable records that support the member has met the medical necessity criteria. **Reauthorization Requests:** **1.** TAR: prior authorization required **2.** Complete PCP: recently reviewed detailing the member's progress with the service. Should include progress towards each of the goals and the involvement in therapy, to include family therapy if reunification is the goal. If family therapy is not occurring in this case, please explain. **3.** CCA: Completed within the last 60 days is required on auths exceeding 240 days. **4.** Step Down/ Discharge Plan: Required, including tentative time frame for discharge **5.** Submission of applicable records that support the member has met the medical necessity criteria.	**Length of Stay**: Up to 60 days for all authorization requests. **Units**: One unit = 1 day **Age Group**: Children & Adolescents **Level of Care**: ASAM Level 3.5 (if applicable). While the LOCUS/ CALOCUS are specifically no longer required, providers are still expected to use a standardized assessment tool when evaluating an individual for treatment services. **Service Specifics, Limitations, & Exclusions (not all inclusive)**: **1.** MCD will not cover this service when the service duplicates another procedure, product, or service.	Clinical Coverage Policy No 8-D-2: Residential Treatment Services APSM 45-2 Records Management and Documentation Manuals PCP Guidance Documents & Templates

Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source
Residential Treatment Services: Level III, Sexually Aggressive Youth (SAY) Program Code(s): **H0019HQ** (4 or less beds) **H0019TJ** (5 or more beds)	Residential treatment provides a structured, therapeutic, and supervised environment to improve the level of functioning for beneficiaries. There are four levels of residential treatment. Residential Treatment Level III Service (Residential Treatment High) has a highly structured and supervised environment in a program setting only. Staff are awake during sleep hours and supervision is continuous.	**Initial Requests:** **1.** TAR: Prior authorization is required, including all items on entrance criteria. **2.** CCA: Required, completed in the 30 days prior to admission and having this service indicated **OR** a signed Continued Need Review (CNR) assessment **OR** a Psychological Eval completed in the last 30 days that addresses all of member's MH and SU needs. Assessment must include an ASAM Score supported with detailed clinical documentation on each of the six ASAM dimensions (if applicable). **3.** Sex Offender Specific Evaluation: Required, completed within the last 6 months, and including an identified risk level. **4.** Complete PCP: Required. **5.** Service Order: Required, signed primary care physician, psychiatrist, or a licensed psychologist. **6.** Child/Adolescent Discharge/Transition Plan **7.** Submission of applicable records that support the member has met the medical necessity criteria. **Reauthorization Requests**: **1.** TAR: prior authorization required **2.** Complete PCP: recently reviewed detailing the member's progress with the service. **3.** Psychiatric/ Psychological Assessment: Required. Must be completed within the last 60 days for authorization requests exceeding 180 days. **4.** Child/Adolescent Discharge/Transition Plan: Required **5.** Submission of applicable records that support the member has met the medical necessity criteria.	**Length of Stay**: Up to 60 days for all authorization requests. **Units**: One unit = 1 day **Age Group**: Children & Adolescents **Level of Care**: ASAM Level 3.5 (if applicable). While the LOCUS/ CALOCUS are specifically no longer required, providers are still expected to use a standardized assessment tool when evaluating an individual for treatment services. **Service Specifics, Limitations, & Exclusions (not all inclusive)**: **1.** MCD will not cover this service when the service duplicates another procedure, product, or service.	Clinical Coverage Policy No 8-D-2: Residential Treatment Services APSM 45-2 Records Management and Documentation Manuals PCP Guidance Documents & Templates Child/Adolescent Discharge/ Transition Plan

Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source
Residential Treatment Services: **Level III (Non-SAY Program)** **Level IV/ Secure** Code(s): **H0019HQ**: Level III, 4 or less beds **H0019TJ**: Level III, 5 or more beds **H0019HK**: Level IV, 4 or less beds **H0019UR**: Level IV, 5 or more beds	Residential treatment provides a structured, therapeutic, and supervised environment to improve the level of functioning for beneficiaries. There are four levels of residential treatment. Residential Treatment Level III Service (Residential Treatment High) has a highly structured and supervised environment in a program setting only. Staff are awake during sleep hours and supervision is continuous. Residential Treatment Level IV Service (Residential Treatment Secure) has a physically secure, locked environment in a program setting only. Staff are awake during sleep hours and supervision is continuous.	**Initial Requests:** **1.** TAR: Prior authorization is required **2.** CCA: Completed within 30 days of admission and has the service indicated. Assessment must include an ASAM Score supported with detailed clinical documentation on each of the six ASAM dimensions (if applicable). **3.** Complete PCP: Required. **4.** Service Order: Required, signed primary care physician, psychiatrist, or a licensed psychologist. **5.** Child/Adolescent Discharge/Transition Plan **6.** Submission of applicable records that support the member has met the medical necessity criteria. **Reauthorization Requests**: **1.** TAR: Prior authorization required **2.** Complete PCP: recently reviewed detailing the member's progress with the service. **3.** Psychiatric/ Psychological Assessment: Required. Must be completed within the last 60 days for authorization requests exceeding 180 days. **4.** Child/Adolescent Discharge/Transition Plan: Required, to include measurable plan with active planning. **5.** Submission of applicable records that support the member has met the medical necessity criteria.	**Length of Stay**: **1.** Up to 60 days for all Level III authorization requests **2.** Up to 30 days for all Level IV authorization requests **Units**: One unit = 1 day **Age Group**: Children & Adolescents **Level of Care**: ASAM Level 3.5 (if applicable). While the LOCUS/ CALOCUS are specifically no longer required, providers are still expected to use a standardized assessment tool when evaluating an individual for treatment services. **Service Specifics, Limitations, & Exclusions (not all inclusive)**: **1.** MCD will not cover this service when the service duplicates another procedure, product, or service.	Clinical Coverage Policy No 8-D-2: Residential Treatment Services APSM 45-2 Records Management and Documentation Manuals PCP Guidance Documents & Templates Child/Adolescent Discharge/ Transition Plan

Service & Code	Brief Service Description	Auth Submission Requirements	Authorization Parameters	Source
Therapeutic Leave for Residential Treatment Services and Psychiatric Residential Treatment Facilities Code(s): 183	Each member who is occupying a tx facility bed for which the Medicaid is paying reimbursement is entitled to take up to 45 (non-consecutive) days of therapeutic leave in any calendar year from any such bed without the facility in which the bed is located suffering any loss of reimbursement during the period of leave. Therapeutic leave shall be defined as the absence of a member from the residential facility overnight, with the expectation of return, to participate in a medically acceptable therapeutic or rehabilitative facility as agreed upon by the treatment team and documented on the tx/ habilitation plan.	**Pass-Through Period:** Prior authorization is not required for this service. **Maintained in the Record (not all inclusive):** **1.** Complete PCP: Required, to include this service. PCP should detailing the member's progress with the service. **2.** Service Order: Required.	**Length of Stay**: Up to15 days of therapeutic leave per quarter, not to exceed 45 days in a calendar year, regardless of the number of facilities used for the service. Therapeutic leave is limited to no more than 15 days within one calendar quarter (three months). Unused days do not carry over to the next quarter. **Units**: One unit = 1 day **Age Group**: Children & Adolescents **Level of Care**: While the LOCUS/ CALOCUS are specifically no longer required, providers are still expected to use a standardized assessment tool when evaluating an individual for treatment services. **Service Specifics, Limitations, & Exclusions (not all inclusive)**: **1.** Facilities must reserve a therapeutically absent member's bed and are prohibited from deriving any Medicaid revenue for that member other than the reimbursement for that bed during the period of absence. Therapeutic leave cannot be billed when Medicaid is paying for any other 24-hour service.	Clinical Coverage Policy No 8-D-2: Residential Treatment Services (CCP 8D2) Clinical Coverage Policy No 8D-1: Psychiatric Residential Treatment Facilities APSM 45-2 Records Management and Documentation Manuals PCP Guidance Documents & Templates