

Medical Necessity Guidelines: Home and Community Based Services (HBTS)

Effective: October 21, 2020

Prior Authorization Required	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
If <u>REQUIRED</u> , submit supporting clinical documentation pertinent to service request.	
Applies to: COMMERCIAL Products <input type="checkbox"/> Tufts Health Plan Commercial products; Fax: 617.972.9409 <input type="checkbox"/> Tufts Health Freedom Plan products; Fax: 617.972.9409 <ul style="list-style-type: none"> CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization TUFTS HEALTH PUBLIC PLANS Products <input type="checkbox"/> Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 888.415.9055 <input type="checkbox"/> Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055 <input checked="" type="checkbox"/> Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404 <input type="checkbox"/> Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304 *The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.	
SENIOR Products <ul style="list-style-type: none"> Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List 	

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW

Home and community-based services (HBTS) are intensive outpatient service within the continuum of care for children and adolescents with special health care needs. HBTS is intended for children and adolescents with moderate to severe special health care needs who experience chronic developmental, cognitive, physical, medical, neurological, behavioral and/or emotional conditions, and whose level of functioning is significantly compromised. The services are intended to meet the needs of the children to attain their fullest potential and to remain as independent as possible within their communities. The Members' health and well-being requires a type and amount of services that exceeds their typically developing peers. Tufts Health RITogether must provide these services to any Medicaid Member under age 21, per federal EPSDT regulation.

HBTS is a phased system approach that includes in person, high frequency, specialized treatment and supervision of direct care staff. The services are provided for children with complex health needs in a holistic, person-and family centered manner; those living at home or in foster care (not specialized DCYF foster care) and delivered in a child's home, community or outpatient setting. Services are provided to improve Member outcomes by integrating social, behavioral health, and physician health needs. HBTS is a medically necessary treatment and not to provide companionship for child/adolescent or Respite for family.

The HBTS level of care requires frequent contact with the child/adolescent and parents/caregivers/guardians engaged in treatment. Treatment is often several hours per day throughout the course of a week. Services may be combined with other outpatient therapies, supports, or education services, but is not to be used as a replacement for other required/recommended therapies.

Note: Although applied behavioral analysis (ABA) is a HBTS service, there is a separate MNG for ABA Therapy for Autism Spectrum Disorders.

CLINICAL COVERAGE CRITERIA

Admission Coverage Criteria

1. Member is less than 21 years of age.
2. The child has a diagnosis and demonstrates symptoms and behavior consistent with a DSM or corresponding ICD psychiatric, medical, or developmental diagnosis made by a licensed health care professional with competence in child psychology child psychiatry, or child development.
3. A less intensive level of care would not be appropriate to meet the Member's needs nor would a more intensive level of care.
4. The child presents with moderate to severe and potentially chronic (12 months or longer in experienced or expected duration) medical and/or physical condition(s) that require intensive therapeutic intervention. The condition(s) manifest impairments that substantially interferes with or limits the Member's role or functioning in family, school or community activities in two or more of the following areas:
 - a. Cognitive functioning: intellectual disability or intellectual developmental disorder.
 - b. Problem solving functioning: judgment, insight, reasoning, impulse control, and/or learning.
 - c. Adaptive skills: communication/speech, dressing, eating, sleeping, or social relatedness.
 - d. Regulation of mood: marked instability of mood (e.g., irritability, depression, anxiety, or mania).
 - e. Functional impairments related to medical/neurological condition.
5. Outpatient services provided at an intensified level have not been sufficient due to the child's special health care needs. (This does not preclude from consideration the role of family therapy or other supports for a family that may be seeking HBTS.)
6. The child and parent/guardian require support in order for the child to remain stable outside of an inpatient environment, or to transition to independent living from a more restrictive setting.
7. The child and parent/guardian are willing to accept and cooperate with HBTS, and agree to be active participants at the level outlined in the HBTS Treatment plan.
8. Member has the capacity to make significant progress towards treatment goals and has the ability to reasonably respond and participate in treatment.
9. Home environment does not pose a safety threat to HBTS staff or there are identified alternative community settings likely to ameliorate the risk.

Continuation Coverage Criteria

All of the following criteria must be met:

1. Member continues to meet admission criteria and another level of care is not appropriate.
2. Evidence suggests that the identified problems will respond to current treatment plan.
3. Parent/guardian continues to require HBTS services in order to improve his/her ability to parent.
4. Treatment is focused on the child and parent/guardian's need for support, guidance, and coaching.
5. All services and supports are tied to achievable measurable goals within a specified timeframe.
6. Member and parent/guardian progress toward goals is monitored regularly. The treatment plan is modified if Member and/ or parent/guardian is not making substantial progress.
7. Progress to specific behaviors, symptoms, or impairments is evident and can be described in objective terms, but:
 - a. Goals have not yet been reached, or
 - b. Adjustments in the treatment plan to address lack of progress are present
8. Frequency of treatment is consistent with the severity of current symptoms.
9. Evidence exists that Member is at current risk for more restrictive level of care if treatment is discontinued.
10. Coordination of care and active discharge planning are occurring.

Discharge Coverage Criteria

Reasons to end HBTS can include any of the following criteria:

1. Treatment Plan goals and objectives have been substantially met and continued services are not necessary.
2. Member no longer meets admission criteria and/or meets criteria for another level of care.
3. Consent for treatment has been withdrawn by a youth 18 or older, or his/her parent(s) or legal guardian(s).
4. Member/parent/guardian is not making progress toward the goals and there is no reasonable expectation of progress with the current treatment plan.
5. Parent/guardian is not engaged in the service to such a degree that this service is effective or safe, despite multiple, documented attempts to remediate.

LIMITATIONS

HBTS is not intended to replace clinically necessary therapies such as behavioral health treatment including emergency treatment, psychiatric care, speech and language therapy, occupational or physical therapy. HBTS represent an integrated set of service components with measurable goals and objectives written and approved by a licensed health care professional¹.

In some instances, the following criteria may also apply:

- The child may be at risk for hospitalization(s) or out-of-home placement without eventual use of HBTS. HBTS is not intended to serve as emergency care and referrals do not provide immediate access. HBTS may not be provided when child and adolescent intensive treatment services (CAITS), child and family intensive treatment (CFIT) or enhanced outpatient services (EOS) are being used².

Exclusions

Any of the following criteria are sufficient for exclusion from this level of care:

1. The Member requires a level of structure and supervision beyond the scope of HBTS.
2. The Member has medical conditions or impairments that would prevent beneficial utilization of services.
3. The Member is living in a specialized foster care setting through DCYF.

CODES

The following codes require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter
T1024	Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter
T1027	Family training and counseling for child development, per 15 minutes
T1028	Assessment of home, physical and family environment, to determine suitability to meet patient's medical needs
H2014	Skills training and development, per 15 minutes
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes
H0037	Community psychiatric supportive treatment program, per diem
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)
H2016	Comprehensive community support services, per diem
H2021	Community-based wrap-around services, per 15 minutes
H2022	Community-based wrap-around services, per diem
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes
G0159	Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes
G0160	Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes

¹ State of Rhode Island, EOHHS Certification Standards Providers of Home Based Therapeutic Services (inclusive of ABA), January 1, 2016, Page 6.

² State of Rhode Island, EOHHS Certification Standards Providers of Home Based Therapeutic Services (inclusive of ABA), January 1, 2016, Page 12.

Code	Description
G0161	Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes
H0037	Community psychiatric supportive treatment program, per diem
H0039	Assertive community treatment, face-to-face, per 15 minutes
H0040	Assertive community treatment program, per diem
H2015	Comprehensive community support services, per 15 minutes
H2016	Comprehensive community support services, per diem
T1040	Medicaid certified community behavioral health clinic services, per diem
T1041	Medicaid certified community behavioral health clinic services, per month

REFERENCES

1. State of Rhode Island Executive Office of Health and Human Services, Certification Standards, Providers of HBTS (Inclusive of ABA), January 1, 2016
2. Solicitation Information, July 14, 2016 for Medicaid Managed Care Services, Attachment 4, Model Contract, Attachment O, Mental Health, Substance Use and Developmental Disabilities Services for Children.

APPROVAL HISTORY

February 8, 2017: Reviewed by the Integrated Medical Policy Advisory Committee for effective date of August 1, 2017.

Subsequent endorsement date(s) and changes made:

- May 10, 2017: Reviewed and approved by IMPAC, based on RI Medicaid recommended edits.
- October 10, 2018: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC), renewed without changes
- October, 2018: Template and disclaimer updated
- October 16, 2019: Reviewed by IMPAC, renewed without changes
- October 21, 2020: Reviewed by IMPAC, renewed without changes
- November 4, 2020: Fax number for Unify updated

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic. [Provider Services](#)